

106TH CONGRESS  
2D SESSION

# H. R. 5661

To amend titles XVIII, XIX, and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare and Medicaid Programs and the State child health insurance program (SCHIP), as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

DECEMBER 14, 2000

Mr. THOMAS (for himself, Mr. BILEY, and Mr. BILIRAKIS) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend titles XVIII, XIX, and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare and Medicaid Programs and the State child health insurance program (SCHIP), as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECUR-**  
 2 **RITY ACT; REFERENCES TO OTHER ACTS;**  
 3 **TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the  
 5 “Medicare, Medicaid, and SCHIP Benefits Improvement  
 6 and Protection Act of 2000”.

7 (b) **AMENDMENTS TO SOCIAL SECURITY ACT.**—Ex-  
 8 cept as otherwise specifically provided, whenever in this  
 9 Act an amendment is expressed in terms of an amendment  
 10 to or repeal of a section or other provision, the reference  
 11 shall be considered to be made to that section or other  
 12 provision of the Social Security Act.

13 (c) **REFERENCES TO OTHER ACTS.**—In this Act:

14 (1) **BALANCED BUDGET ACT OF 1997.**—The  
 15 term “BBA” means the Balanced Budget Act of  
 16 1997 (Public Law 105–33; 111 Stat. 251).

17 (2) **MEDICARE, MEDICAID, AND SCHIP BAL-**  
 18 **ANCED BUDGET REFINEMENT ACT OF 1999.**—The  
 19 term “BBRA” means the Medicare, Medicaid, and  
 20 SCHIP Balanced Budget Refinement Act of 1999  
 21 (Appendix F, 113 Stat. 1501A–321), as enacted into  
 22 law by section 1000(a)(6) of Public Law 106–113.

23 (d) **TABLE OF CONTENTS.**—The table of contents of  
 24 this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to other Acts;  
 table of contents.

## TITLE I—MEDICARE BENEFICIARY IMPROVEMENTS

## Subtitle A—Improved Preventive Benefits

- Sec. 101. Coverage of biennial screening pap smear and pelvic exams.
- Sec. 102. Coverage of screening for glaucoma.
- Sec. 103. Coverage of screening colonoscopy for average risk individuals.
- Sec. 104. Modernization of screening mammography benefit.
- Sec. 105. Coverage of medical nutrition therapy services for beneficiaries with diabetes or a renal disease.

## Subtitle B—Other Beneficiary Improvements

- Sec. 111. Acceleration of reduction of beneficiary copayment for hospital outpatient department services.
- Sec. 112. Preservation of coverage of drugs and biologicals under part B of the medicare program.
- Sec. 113. Elimination of time limitation on medicare benefits for immunosuppressive drugs.
- Sec. 114. Imposition of billing limits on drugs.
- Sec. 115. Waiver of 24-month waiting period for medicare coverage of individuals disabled with amyotrophic lateral sclerosis (ALS).

## Subtitle C—Demonstration Projects and Studies

- Sec. 121. Demonstration project for disease management for severely chronically ill medicare beneficiaries.
- Sec. 122. Cancer prevention and treatment demonstration for ethnic and racial minorities.
- Sec. 123. Study on medicare coverage of routine thyroid screening.
- Sec. 124. MedPAC study on consumer coalitions.
- Sec. 125. Study on limitation on State payment for medicare cost-sharing affecting access to services for qualified medicare beneficiaries.
- Sec. 126. Studies on preventive interventions in primary care for older Americans.
- Sec. 127. MedPAC study and report on medicare coverage of cardiac and pulmonary rehabilitation therapy services.
- Sec. 128. Lifestyle modification program demonstration.

## TITLE II—RURAL HEALTH CARE IMPROVEMENTS

## Subtitle A—Critical Access Hospital Provisions

- Sec. 201. Clarification of no beneficiary cost-sharing for clinical diagnostic laboratory tests furnished by critical access hospitals.
- Sec. 202. Assistance with fee schedule payment for professional services under all-inclusive rate.
- Sec. 203. Exemption of critical access hospital swing beds from SNF PPS.
- Sec. 204. Payment in critical access hospitals for emergency room on-call physicians.
- Sec. 205. Treatment of ambulance services furnished by certain critical access hospitals.
- Sec. 206. GAO study on certain eligibility requirements for critical access hospitals.

## Subtitle B—Other Rural Hospitals Provisions

- Sec. 211. Treatment of rural disproportionate share hospitals.

- Sec. 212. Option to base eligibility for medicare dependent, small rural hospital program on discharges during two of the three most recently audited cost reporting periods.
- Sec. 213. Extension of option to use rebased target amounts to all sole community hospitals.
- Sec. 214. MedPAC analysis of impact of volume on per unit cost of rural hospitals with psychiatric units.

#### Subtitle C—Other Rural Provisions

- Sec. 221. Assistance for providers of ambulance services in rural areas.
- Sec. 222. Payment for certain physician assistant services.
- Sec. 223. Revision of medicare reimbursement for telehealth services.
- Sec. 224. Expanding access to rural health clinics.
- Sec. 225. MedPAC study on low-volume, isolated rural health care providers.

### TITLE III—PROVISIONS RELATING TO PART A

#### Subtitle A—Inpatient Hospital Services

- Sec. 301. Revision of acute care hospital payment update for 2001.
- Sec. 302. Additional modification in transition for indirect medical education (IME) percentage adjustment.
- Sec. 303. Decrease in reductions for disproportionate share hospital (DSH) payments.
- Sec. 304. Wage index improvements.
- Sec. 305. Payment for inpatient services of rehabilitation hospitals.
- Sec. 306. Payment for inpatient services of psychiatric hospitals.
- Sec. 307. Payment for inpatient services of long-term care hospitals.

#### Subtitle B—Adjustments to PPS Payments for Skilled Nursing Facilities

- Sec. 311. Elimination of reduction in skilled nursing facility (SNF) market basket update in 2001.
- Sec. 312. Increase in nursing component of PPS Federal rate.
- Sec. 313. Application of SNF consolidated billing requirement limited to part A covered stays.
- Sec. 314. Adjustment of rehabilitation RUGs to correct anomaly in payment rates.
- Sec. 315. Establishment of process for geographic reclassification.

#### Subtitle C—Hospice Care

- Sec. 321. Five percent increase in payment base.
- Sec. 322. Clarification of physician certification.
- Sec. 323. MedPAC report on access to, and use of, hospice benefit.

#### Subtitle D—Other Provisions

- Sec. 331. Relief from medicare part A late enrollment penalty for group buy-in for State and local retirees.

### TITLE IV—PROVISIONS RELATING TO PART B

#### Subtitle A—Hospital Outpatient Services

- Sec. 401. Revision of hospital outpatient PPS payment update.

- Sec. 402. Clarifying process and standards for determining eligibility of devices for pass-through payments under hospital outpatient PPS.
- Sec. 403. Application of OPD PPS transitional corridor payments to certain hospitals that did not submit a 1996 cost report.
- Sec. 404. Application of rules for determining provider-based status for certain entities.
- Sec. 405. Treatment of children's hospitals under prospective payment system.
- Sec. 406. Inclusion of temperature monitored cryoablation in transitional pass-through for certain medical devices, drugs, and biologicals under OPD PPS.

#### Subtitle B—Provisions Relating to Physicians' Services

- Sec. 411. GAO studies relating to physicians' services.
- Sec. 412. Physician group practice demonstration.
- Sec. 413. Study on enrollment procedures for groups that retain independent contractor physicians.

#### Subtitle C—Other Services

- Sec. 421. One-year extension of moratorium on therapy caps; report on standards for supervision of physical therapy assistants.
- Sec. 422. Update in renal dialysis composite rate.
- Sec. 423. Payment for ambulance services.
- Sec. 424. Ambulatory surgical centers.
- Sec. 425. Full update for durable medical equipment.
- Sec. 426. Full update for orthotics and prosthetics.
- Sec. 427. Establishment of special payment provisions and requirements for prosthetics and certain custom-fabricated orthotic items.
- Sec. 428. Replacement of prosthetic devices and parts.
- Sec. 429. Revised part B payment for drugs and biologicals and related services.
- Sec. 430. Contrast enhanced diagnostic procedures under hospital prospective payment system.
- Sec. 431. Qualifications for community mental health centers.
- Sec. 432. Payment of physician and nonphysician services in certain Indian providers.
- Sec. 433. GAO study on coverage of surgical first assisting services of certified registered nurse first assistants.
- Sec. 434. MedPAC study and report on medicare reimbursement for services provided by certain providers.
- Sec. 435. MedPAC study and report on medicare coverage of services provided by certain nonphysician providers.
- Sec. 436. GAO study and report on the costs of emergency and medical transportation services.
- Sec. 437. GAO studies and reports on medicare payments.
- Sec. 438. MedPAC study on access to outpatient pain management services.

### TITLE V—PROVISIONS RELATING TO PARTS A AND B

#### Subtitle A—Home Health Services

- Sec. 501. One-year additional delay in application of 15 percent reduction on payment limits for home health services.
- Sec. 502. Restoration of full home health market basket update for home health services for fiscal year 2001.
- Sec. 503. Temporary two-month periodic interim payment.

- Sec. 504. Use of telehealth in delivery of home health services.
- Sec. 505. Study on costs to home health agencies of purchasing nonroutine medical supplies.
- Sec. 506. Treatment of branch offices; GAO study on supervision of home health care provided in isolated rural areas.
- Sec. 507. Clarification of the homebound definition under the medicare home health benefit.
- Sec. 508. Temporary increase for home health services furnished in a rural area.

#### Subtitle B—Direct Graduate Medical Education

- Sec. 511. Increase in floor for direct graduate medical education payments.
- Sec. 512. Change in distribution formula for Medicare+Choice-related nursing and allied health education costs.

#### Subtitle C—Changes in Medicare Coverage and Appeals Process

- Sec. 521. Revisions to medicare appeals process.
- Sec. 522. Revisions to medicare coverage process.

#### Subtitle D—Improving Access to New Technologies

- Sec. 531. Reimbursement improvements for new clinical laboratory tests and durable medical equipment.
- Sec. 532. Retention of HCPCS level III codes.
- Sec. 533. Recognition of new medical technologies under inpatient hospital PPS.

#### Subtitle E—Other Provisions

- Sec. 541. Increase in reimbursement for bad debt.
- Sec. 542. Treatment of certain physician pathology services under medicare.
- Sec. 543. Extension of advisory opinion authority.
- Sec. 544. Change in annual MedPAC reporting.
- Sec. 545. Development of patient assessment instruments.
- Sec. 546. GAO report on impact of the Emergency Medical Treatment and Active Labor Act (EMTALA) on hospital emergency departments.
- Sec. 547. Clarification of application of temporary payment increases for 2001.

### TITLE VI—PROVISIONS RELATING TO PART C (MEDICARE+CHOICE PROGRAM) AND OTHER MEDICARE MAN- AGED CARE PROVISIONS

#### Subtitle A—Medicare+Choice Payment Reforms

- Sec. 601. Increase in minimum payment amount.
- Sec. 602. Increase in minimum percentage increase.
- Sec. 603. Phase-in of risk adjustment.
- Sec. 604. Transition to revised Medicare+Choice payment rates.
- Sec. 605. Revision of payment rates for ESRD patients enrolled in Medicare+Choice plans.
- Sec. 606. Permitting premium reductions as additional benefits under Medicare+Choice plans.
- Sec. 607. Full implementation of risk adjustment for congestive heart failure enrollees for 2001.
- Sec. 608. Expansion of application of Medicare+Choice new entry bonus.

Sec. 609. Report on inclusion of certain costs of the Department of Veterans Affairs and military facility services in calculating Medicare+Choice payment rates.

#### Subtitle B—Other Medicare+Choice Reforms

Sec. 611. Payment of additional amounts for new benefits covered during a contract term.

Sec. 612. Restriction on implementation of significant new regulatory requirements midyear.

Sec. 613. Timely approval of marketing material that follows model marketing language.

Sec. 614. Avoiding duplicative regulation.

Sec. 615. Election of uniform local coverage policy for Medicare+Choice plan covering multiple localities.

Sec. 616. Eliminating health disparities in Medicare+Choice program.

Sec. 617. Medicare+Choice program compatibility with employer or union group health plans.

Sec. 618. Special medigap enrollment antidiscrimination provision for certain beneficiaries.

Sec. 619. Restoring effective date of elections and changes of elections of Medicare+Choice plans.

Sec. 620. Permitting ESRD beneficiaries to enroll in another Medicare+Choice plan if the plan in which they are enrolled is terminated.

Sec. 621. Providing choice for skilled nursing facility services under the Medicare+Choice program.

Sec. 622. Providing for accountability of Medicare+Choice plans.

Sec. 623. Increased civil money penalty for Medicare+Choice organizations that terminate contracts mid-year.

#### Subtitle C—Other Managed Care Reforms

Sec. 631. One-year extension of social health maintenance organization (SHMO) demonstration project.

Sec. 632. Revised terms and conditions for extension of medicare community nursing organization (CNO) demonstration project.

Sec. 633. Extension of medicare municipal health services demonstration projects.

Sec. 634. Service area expansion for medicare cost contracts during transition period.

### TITLE VII—MEDICAID

Sec. 701. DSH payments.

Sec. 702. New prospective payment system for Federally-qualified health centers and rural health clinics.

Sec. 703. Streamlined approval of continued State-wide section 1115 medicaid waivers.

Sec. 704. Medicaid county-organized health systems.

Sec. 705. Deadline for issuance of final regulation relating to medicaid upper payment limits.

Sec. 706. Alaska FMAP.

Sec. 707. One-year extension of welfare-to-work transition.

Sec. 708. Additional entities qualified to determine medicaid presumptive eligibility for low-income children.

Sec. 709. Development of uniform QMB/SLMB application form.

Sec. 710. Technical corrections.

#### TITLE VIII—STATE CHILDREN’S HEALTH INSURANCE PROGRAM

Sec. 801. Special rule for redistribution and availability of unused fiscal year 1998 and 1999 SCHIP allotments.

Sec. 802. Authority to pay medicaid expansion SCHIP costs from title XXI appropriation.

Sec. 803. Application of medicaid child presumptive eligibility provisions.

#### TITLE IX—OTHER PROVISIONS

##### Subtitle A—PACE Program

Sec. 901. Extension of transition for current waivers.

Sec. 902. Continuing of certain operating arrangements permitted.

Sec. 903. Flexibility in exercising waiver authority.

##### Subtitle B—Outreach to Eligible Low-Income Medicare Beneficiaries

Sec. 911. Outreach on availability of medicare cost-sharing assistance to eligible low-income medicare beneficiaries.

##### Subtitle C—Maternal and Child Health Block Grant

Sec. 921. Increase in authorization of appropriations for the maternal and child health services block grant.

##### Subtitle D—Diabetes

Sec. 931. Increase in appropriations for special diabetes programs for type I diabetes and Indians.

Sec. 932. Appropriations for Ricky Ray Hemophilia Relief Fund.

##### Subtitle E—Information on Nursing Facility Staffing

Sec. 941. Posting of information on nursing facility staffing.

##### Subtitle F—Adjustment of Multiemployer Plan Benefits Guaranteed

Sec. 951. Multiemployer plan benefits guaranteed.

1                   **TITLE I—MEDICARE**  
 2                   **BENEFICIARY IMPROVEMENTS**  
 3                   **Subtitle A—Improved Preventive**  
 4                   **Benefits**  
 5                   **SEC. 101. COVERAGE OF BIENNIAL SCREENING PAP SMEAR**  
 6                   **AND PELVIC EXAMS.**  
 7                   (a) IN GENERAL.—



1 (1) BIENNIAL SCREENING PAP SMEAR.—Section  
2 1861(nn)(1) (42 U.S.C. 1395x(nn)(1)) is amended  
3 by striking “3 years” and inserting “2 years”.

4 (2) BIENNIAL SCREENING PELVIC EXAM.—Sec-  
5 tion 1861(nn)(2) (42 U.S.C. 1395x(nn)(2)) is  
6 amended by striking “3 years” and inserting “2  
7 years”.

8 (b) EFFECTIVE DATE.—The amendments made by  
9 subsection (a) shall apply to items and services furnished  
10 on or after July 1, 2001.

11 **SEC. 102. COVERAGE OF SCREENING FOR GLAUCOMA.**

12 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.  
13 1395x(s)(2)) is amended—

14 (1) by striking “and” at the end of subpara-  
15 graph (S);

16 (2) by inserting “and” at the end of subpara-  
17 graph (T); and

18 (3) by adding at the end the following:

19 “(U) screening for glaucoma (as defined in sub-  
20 section (uu)) for individuals determined to be at  
21 high risk for glaucoma, individuals with a family his-  
22 tory of glaucoma and individuals with diabetes;”.

23 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.  
24 1395x) is amended by adding at the end the following new  
25 subsection:

## 1 “Screening for Glaucoma

2 “(uu) The term ‘screening for glaucoma’ means a di-  
3 lated eye examination with an intraocular pressure meas-  
4 urement, and a direct ophthalmoscopy or a slit-lamp bio-  
5 microscopic examination for the early detection of glau-  
6 coma which is furnished by or under the direct supervision  
7 of an optometrist or ophthalmologist who is legally author-  
8 ized to furnish such services under State law (or the State  
9 regulatory mechanism provided by State law) of the State  
10 in which the services are furnished, as would otherwise  
11 be covered if furnished by a physician or as an incident  
12 to a physician’s professional service, if the individual in-  
13 volved has not had such an examination in the preceding  
14 year.”.

15 (c) CONFORMING AMENDMENT.—Section  
16 1862(a)(1)(F) (42 U.S.C. 1395y(a)(1)(F)) is amended—

17 (1) by striking “and,”; and

18 (2) by adding at the end the following: “and, in  
19 the case of screening for glaucoma, which is per-  
20 formed more frequently than is provided under sec-  
21 tion 1861(uu),”.

22 (d) EFFECTIVE DATE.—The amendments made by  
23 this section shall apply to services furnished on or after  
24 January 1, 2002.

1 **SEC. 103. COVERAGE OF SCREENING COLONOSCOPY FOR**  
2 **AVERAGE RISK INDIVIDUALS.**

3 (a) IN GENERAL.—Section 1861(pp) (42 U.S.C.  
4 1395x(pp)) is amended—

5 (1) in paragraph (1)(C), by striking “In the  
6 case of an individual at high risk for colorectal can-  
7 cer, screening colonoscopy” and inserting “Screening  
8 colonoscopy”; and

9 (2) in paragraph (2), by striking “In paragraph  
10 (1)(C), an” and inserting “An”.

11 (b) FREQUENCY LIMITS FOR SCREENING  
12 COLONOSCOPY.—Section 1834(d) (42 U.S.C. 1395m(d))  
13 is amended—

14 (1) in paragraph (2)(E)(ii), by inserting before  
15 the period at the end the following: “or, in the case  
16 of an individual who is not at high risk for colorectal  
17 cancer, if the procedure is performed within the 119  
18 months after a previous screening colonoscopy”; and

19 (2) in paragraph (3)—

20 (A) in the heading by striking “FOR INDIV-  
21 IDUALS AT HIGH RISK FOR COLORECTAL CAN-  
22 CER”;

23 (B) in subparagraph (A), by striking “for  
24 individuals at high risk for colorectal cancer (as  
25 defined in section 1861(pp)(2))”; and

1 (C) in subparagraph (E), by inserting be-  
 2 fore the period at the end the following: “or for  
 3 other individuals if the procedure is performed  
 4 within the 119 months after a previous screen-  
 5 ing colonoscopy or within 47 months after a  
 6 previous screening flexible sigmoidoscopy”.

7 (c) EFFECTIVE DATE.—The amendments made by  
 8 this section shall apply to colorectal cancer screening serv-  
 9 ices provided on or after July 1, 2001.

10 **SEC. 104. MODERNIZATION OF SCREENING MAMMOGRAPHY**  
 11 **BENEFIT.**

12 (a) INCLUSION IN PHYSICIAN FEE SCHEDULE.—Sec-  
 13 tion 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)) is amended by  
 14 inserting “(13),” after “(4),”.

15 (b) CONFORMING AMENDMENT.—Section 1834(c)  
 16 (42 U.S.C. 1395m(c)) is amended to read as follows:

17 “(c) PAYMENT AND STANDARDS FOR SCREENING  
 18 MAMMOGRAPHY.—

19 “(1) IN GENERAL.—With respect to expenses  
 20 incurred for screening mammography (as defined in  
 21 section 1861(jj)), payment may be made only—

22 “(A) for screening mammography con-  
 23 ducted consistent with the frequency permitted  
 24 under paragraph (2); and

1           “(B) if the screening mammography is  
2           conducted by a facility that has a certificate (or  
3           provisional certificate) issued under section 354  
4           of the Public Health Service Act.

5           “(2) FREQUENCY COVERED.—

6           “(A) IN GENERAL.—Subject to revision by  
7           the Secretary under subparagraph (B)—

8                   “(i) no payment may be made under  
9                   this part for screening mammography per-  
10                  formed on a woman under 35 years of age;

11                  “(ii) payment may be made under this  
12                  part for only one screening mammography  
13                  performed on a woman over 34 years of  
14                  age, but under 40 years of age; and

15                  “(iii) in the case of a woman over 39  
16                  years of age, payment may not be made  
17                  under this part for screening mammog-  
18                  raphy performed within 11 months fol-  
19                  lowing the month in which a previous  
20                  screening mammography was performed.

21           “(B) REVISION OF FREQUENCY.—

22                   “(i) REVIEW.—The Secretary, in con-  
23                   sultation with the Director of the National  
24                   Cancer Institute, shall review periodically  
25                   the appropriate frequency for performing

1 screening mammography, based on age  
2 and such other factors as the Secretary be-  
3 lieves to be pertinent.

4 “(ii) REVISION OF FREQUENCY.—The  
5 Secretary, taking into consideration the re-  
6 view made under clause (i), may revise  
7 from time to time the frequency with  
8 which screening mammography may be  
9 paid for under this subsection.”.

10 (c) EFFECTIVE DATE.—The amendments made by  
11 subsections (a) and (b) shall apply with respect to screen-  
12 ing mammographies furnished on or after January 1,  
13 2002.

14 (d) PAYMENT FOR NEW TECHNOLOGIES.—

15 (1) TESTS FURNISHED IN 2001.—

16 (A) SCREENING.—For a screening mam-  
17 mography (as defined in section 1861(jj) of the  
18 Social Security Act (42 U.S.C. 1395x(jj))) fur-  
19 nished during the period beginning on April 1,  
20 2001, and ending on December 31, 2001, that  
21 uses a new technology, payment for such  
22 screening mammography shall be made as fol-  
23 lows:

24 (i) In the case of a technology which  
25 directly takes a digital image (without in-

1           volving film), in an amount equal to 150  
2           percent of the amount of payment under  
3           section 1848 of such Act (42 U.S.C.  
4           1395w-4) for a bilateral diagnostic mam-  
5           mography (under HCPCS code 76091) for  
6           such year.

7           (ii) In the case of a technology which  
8           allows conversion of a standard film mam-  
9           mogram into a digital image and subse-  
10          quently analyzes such resulting image with  
11          software to identify possible problem areas,  
12          in an amount equal to the limit that would  
13          otherwise be applied under section  
14          1834(c)(3) of such Act (42 U.S.C.  
15          1395m(c)(3)) for 2001, increased by \$15.

16          (B) BILATERAL DIAGNOSTIC MAMMOG-  
17          RAPHY.—For a bilateral diagnostic mammog-  
18          raphy furnished during the period beginning on  
19          April 1, 2001, and ending on December 31,  
20          2001, that uses a new technology described in  
21          subparagraph (A), payment for such mammog-  
22          raphy shall be the amount of payment provided  
23          for under such subparagraph.

24          (C) ALLOCATION OF AMOUNTS.—The Sec-  
25          retary shall provide for an appropriate alloca-

tion of the amounts under subparagraphs (A) and (B) between the professional and technical components.

(D) IMPLEMENTATION OF PROVISION.—

The Secretary of Health and Human Services may implement the provisions of this paragraph by program memorandum or otherwise.

(2) CONSIDERATION OF NEW HCPCS CODE FOR

NEW TECHNOLOGIES AFTER 2001.—The Secretary

shall determine, for such mammographies performed

after 2001, whether the assignment of a new

HCPCS code is appropriate for mammography that

uses a new technology. If the Secretary determines

that a new code is appropriate for such mammog-

raphy, the Secretary shall provide for such new code

for such tests furnished after 2001.

(3) NEW TECHNOLOGY DESCRIBED.—For pur-

poses of this subsection, a new technology with re-

spect to a mammography is an advance in tech-

nology with respect to the test or equipment that re-

sults in the following:

(A) A significant increase or decrease in

the resources used in the test or in the manu-

facture of the equipment.



1 (B) A significant improvement in the per-  
 2 formance of the test or equipment.

3 (C) A significant advance in medical tech-  
 4 nology that is expected to significantly improve  
 5 the treatment of medicare beneficiaries.

6 (4) HCPCS CODE DEFINED.—The term  
 7 “HCPCS code” means a code under the Health  
 8 Care Financing Administration Common Procedure  
 9 Coding System (HCPCS).

10 **SEC. 105. COVERAGE OF MEDICAL NUTRITION THERAPY**  
 11 **SERVICES FOR BENEFICIARIES WITH DIABE-**  
 12 **TES OR A RENAL DISEASE.**

13 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.  
 14 1395x(s)(2)), as amended by section 102(a), is amended—

15 (1) in subparagraph (T), by striking “and” at  
 16 the end;

17 (2) in subparagraph (U), by inserting “and” at  
 18 the end; and

19 (3) by adding at the end the following new sub-  
 20 paragraph:

21 “(V) medical nutrition therapy services (as de-  
 22 fined in subsection (vv)(1)) in the case of a bene-  
 23 ficiary with diabetes or a renal disease who—

1           “(i) has not received diabetes outpatient  
2           self-management training services within a time  
3           period determined by the Secretary;

4           “(ii) is not receiving maintenance dialysis  
5           for which payment is made under section 1881;  
6           and

7           “(iii) meets such other criteria determined  
8           by the Secretary after consideration of protocols  
9           established by dietitian or nutrition professional  
10          organizations;”.

11          (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.  
12   1395x), as amended by section 102(b), is amended by add-  
13   ing at the end the following:

14          “Medical Nutrition Therapy Services; Registered  
15                  Dietitian or Nutrition Professional

16          “(vv)(1) The term ‘medical nutrition therapy serv-  
17   ices’ means nutritional diagnostic, therapy, and counseling  
18   services for the purpose of disease management which are  
19   furnished by a registered dietitian or nutrition profes-  
20   sional (as defined in paragraph (2)) pursuant to a referral  
21   by a physician (as defined in subsection (r)(1)).

22          “(2) Subject to paragraph (3), the term ‘registered  
23   dietitian or nutrition professional’ means an individual  
24   who—

1           “(A) holds a baccalaureate or higher degree  
2           granted by a regionally accredited college or univer-  
3           sity in the United States (or an equivalent foreign  
4           degree) with completion of the academic require-  
5           ments of a program in nutrition or dietetics, as ac-  
6           credited by an appropriate national accreditation or-  
7           ganization recognized by the Secretary for this pur-  
8           pose;

9           “(B) has completed at least 900 hours of super-  
10          vised dietetics practice under the supervision of a  
11          registered dietitian or nutrition professional; and

12          “(C)(i) is licensed or certified as a dietitian or  
13          nutrition professional by the State in which the serv-  
14          ices are performed; or

15          “(ii) in the case of an individual in a State that  
16          does not provide for such licensure or certification,  
17          meets such other criteria as the Secretary estab-  
18          lishes.

19          “(3) Subparagraphs (A) and (B) of paragraph (2)  
20          shall not apply in the case of an individual who, as of the  
21          date of the enactment of this subsection, is licensed or cer-  
22          tified as a dietitian or nutrition professional by the State  
23          in which medical nutrition therapy services are per-  
24          formed.”.

1       (c) PAYMENT.—Section 1833(a)(1) (42 U.S.C.  
2 1395l(a)(1)) is amended—

3           (1) by striking “and” before “(S)”; and

4           (2) by inserting before the semicolon at the end  
5 the following: “, and (T) with respect to medical nu-  
6 trition therapy services (as defined in section  
7 1861(vv)), the amount paid shall be 80 percent of  
8 the lesser of the actual charge for the services or 85  
9 percent of the amount determined under the fee  
10 schedule established under section 1848(b) for the  
11 same services if furnished by a physician”.

12       (d) APPLICATION OF LIMITS ON BILLING.—Section  
13 1842(b)(18)(C) (42 U.S.C. 1395u(b)(18)(C)) is amended  
14 by adding at the end the following new clause:

15           “(vi) A registered dietitian or nutrition profes-  
16 sional.”.

17       (e) EFFECTIVE DATE.—The amendments made by  
18 this section shall apply to services furnished on or after  
19 January 1, 2002.

20       (f) STUDY.—Not later than July 1, 2003, the Sec-  
21 retary of Health and Human Services shall submit to Con-  
22 gress a report that contains recommendations with respect  
23 to the expansion to other medicare beneficiary populations  
24 of the medical nutrition therapy services benefit (furnished  
25 under the amendments made by this section).

**Subtitle B—Other Beneficiary  
Improvements**

**SEC. 111. ACCELERATION OF REDUCTION OF BENEFICIARY  
COPAYMENT FOR HOSPITAL OUTPATIENT DE-  
PARTMENT SERVICES.**

(a) REDUCING THE UPPER LIMIT ON BENEFICIARY  
COPAYMENT.—

(1) IN GENERAL.—Section 1833(t)(8)(C) (42  
U.S.C. 1395l(t)(8)(C)) is amended to read as fol-  
lows:

“(C) LIMITATION ON COPAYMENT  
AMOUNT.—

“(i) TO INPATIENT HOSPITAL DE-  
DUCTIBLE AMOUNT.—In no case shall the  
copayment amount for a procedure per-  
formed in a year exceed the amount of the  
inpatient hospital deductible established  
under section 1813(b) for that year.

“(ii) TO SPECIFIED PERCENTAGE.—  
The Secretary shall reduce the national  
unadjusted copayment amount for a cov-  
ered OPD service (or group of such serv-  
ices) furnished in a year in a manner so  
that the effective copayment rate (deter-  
mined on a national unadjusted basis) for

1                   that service in the year does not exceed the  
2                   following percentage:

3                   “(I) For procedures performed in  
4                   2001, on or after April 1, 2001, 57  
5                   percent.

6                   “(II) For procedures performed  
7                   in 2002 or 2003, 55 percent.

8                   “(III) For procedures performed  
9                   in 2004, 50 percent.

10                  “(IV) For procedures performed  
11                  in 2005, 45 percent.

12                  “(V) For procedures performed  
13                  in 2006 and thereafter, 40 percent.”.

14                  (2) EFFECTIVE DATE.—The amendment made  
15                  by paragraph (1) shall apply with respect to services  
16                  furnished on or after April 1, 2001.

17                  (b) CONSTRUCTION REGARDING LIMITING IN-  
18 CREASES IN COST-SHARING.—Nothing in this Act or the  
19 Social Security Act shall be construed as preventing a hos-  
20 pital from waiving the amount of any coinsurance for out-  
21 patient hospital services under the medicare program  
22 under title XVIII of the Social Security Act that may have  
23 been increased as a result of the implementation of the  
24 prospective payment system under section 1833(t) of the  
25 Social Security Act (42 U.S.C. 1395l(t)).

1       (c) GAO STUDY OF REDUCTION IN MEDIGAP PRE-  
 2 MIUM LEVELS RESULTING FROM REDUCTIONS IN COIN-  
 3 SURANCE.—The Comptroller General of the United States  
 4 shall work, in concert with the National Association of In-  
 5 surance Commissioners, to evaluate the extent to which  
 6 the premium levels for medicare supplemental policies re-  
 7 flect the reductions in coinsurance resulting from the  
 8 amendment made by subsection (a). Not later than April  
 9 1, 2004, the Comptroller General shall submit to Congress  
 10 a report on such evaluation and the extent to which the  
 11 reductions in beneficiary coinsurance effected by such  
 12 amendment have resulted in actual savings to medicare  
 13 beneficiaries.

14 **SEC. 112. PRESERVATION OF COVERAGE OF DRUGS AND**  
 15 **BIOLOGICALS UNDER PART B OF THE MEDI-**  
 16 **CARE PROGRAM.**

17       (a) IN GENERAL.—Section 1861(s)(2) (42 U.S.C.  
 18 1395x(s)(2)) is amended, in each of subparagraphs (A)  
 19 and (B), by striking “(including drugs and biologicals  
 20 which cannot, as determined in accordance with regula-  
 21 tions, be self-administered)” and inserting “(including  
 22 drugs and biologicals which are not usually self-adminis-  
 23 tered by the patient)”.

1 (b) EFFECTIVE DATE.—The amendment made by  
 2 subsection (a) shall apply to drugs and biologicals admin-  
 3 istered on or after the date of the enactment of this Act.

4 **SEC. 113. ELIMINATION OF TIME LIMITATION ON MEDI-**  
 5 **CARE BENEFITS FOR IMMUNOSUPPRESSIVE**  
 6 **DRUGS.**

7 (a) IN GENERAL.—Section 1861(s)(2)(J) (42 U.S.C.  
 8 1395x(s)(2)(J)) is amended by striking “, but only” and  
 9 all that follows up to the semicolon at the end.

10 (b) CONFORMING AMENDMENTS.—

11 (1) EXTENDED COVERAGE.—Section 1832 (42  
 12 U.S.C. 1395k) is amended—

13 (A) by striking subsection (b); and

14 (B) by redesignating subsection (c) as sub-  
 15 section (b).

16 (2) PASS-THROUGH; REPORT.—Section 227 of  
 17 BBRA is amended by striking subsection (d).

18 (c) EFFECTIVE DATE.—The amendment made by  
 19 subsection (a) shall apply to drugs furnished on or after  
 20 the date of the enactment of this Act.

21 **SEC. 114. IMPOSITION OF BILLING LIMITS ON DRUGS.**

22 (a) IN GENERAL.—Section 1842(o) (42 U.S.C.  
 23 1395u(o)) is amended by adding at the end the following  
 24 new paragraph:



1 “(3)(A) Payment for a charge for any drug or biologi-  
 2 cal for which payment may be made under this part may  
 3 be made only on an assignment-related basis.

4 “(B) The provisions of subsection (b)(18)(B) shall  
 5 apply to charges for such drugs or biologicals in the same  
 6 manner as they apply to services furnished by a practi-  
 7 tioner described in subsection (b)(18)(C).”.

8 (b) EFFECTIVE DATE.—The amendment made by  
 9 subsection (a) shall apply to items furnished on or after  
 10 January 1, 2001.

11 **SEC. 115. WAIVER OF 24-MONTH WAITING PERIOD FOR**  
 12 **MEDICARE COVERAGE OF INDIVIDUALS DIS-**  
 13 **ABLED WITH AMYOTROPHIC LATERAL SCLE-**  
 14 **ROSIS (ALS).**

15 (a) IN GENERAL.—Section 226 (42 U.S.C. 426) is  
 16 amended—

17 (1) by redesignating subsection (h) as sub-  
 18 section (j) and by moving such subsection to the end  
 19 of the section; and

20 (2) by inserting after subsection (g) the fol-  
 21 lowing new subsection:

22 “(h) For purposes of applying this section in the case  
 23 of an individual medically determined to have amyotrophic  
 24 lateral sclerosis (ALS), the following special rules apply:

1           “(1) Subsection (b) shall be applied as if there  
2       were no requirement for any entitlement to benefits,  
3       or status, for a period longer than 1 month.

4           “(2) The entitlement under such subsection  
5       shall begin with the first month (rather than twenty-  
6       fifth month) of entitlement or status.

7           “(3) Subsection (f) shall not be applied.”.

8       (b) CONFORMING AMENDMENT.—Section 1837 (42  
9   U.S.C. 1395p) is amended by adding at the end the fol-  
10   lowing new subsection:

11       “(j) In applying this section in the case of an indi-  
12   vidual who is entitled to benefits under part A pursuant  
13   to the operation of section 226(h), the following special  
14   rules apply:

15           “(1) The initial enrollment period under sub-  
16       section (d) shall begin on the first day of the first  
17       month in which the individual satisfies the require-  
18       ment of section 1836(1).

19           “(2) In applying subsection (g)(1), the initial  
20       enrollment period shall begin on the first day of the  
21       first month of entitlement to disability insurance  
22       benefits referred to in such subsection.”.

23       (c) EFFECTIVE DATE.—The amendments made by  
24   this section shall apply to benefits for months beginning  
25   July 1, 2001.

## **Subtitle C—Demonstration Projects and Studies**

### **SEC. 121. DEMONSTRATION PROJECT FOR DISEASE MANAGEMENT FOR SEVERELY CHRONICALLY ILL MEDICARE BENEFICIARIES.**

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project under this section (in this section referred to as the “project”) to demonstrate the impact on costs and health outcomes of applying disease management to medicare beneficiaries with diagnosed, advanced-stage congestive heart failure, diabetes, or coronary heart disease. In no case may the number of participants in the project exceed 30,000 at any time.

#### **(b) VOLUNTARY PARTICIPATION.—**

(1) ELIGIBILITY.—Medicare beneficiaries are eligible to participate in the project only if—

(A) they meet specific medical criteria demonstrating the appropriate diagnosis and the advanced nature of their disease;

(B) their physicians approve of participation in the project; and

(C) they are not enrolled in a Medicare+Choice plan.

1           (2) BENEFITS.—A beneficiary who is enrolled  
2           in the project shall be eligible—

3                   (A) for disease management services re-  
4                   lated to their chronic health condition; and

5                   (B) for payment for all costs for prescrip-  
6                   tion drugs without regard to whether or not  
7                   they relate to the chronic health condition, ex-  
8                   cept that the project may provide for modest  
9                   cost-sharing with respect to prescription drug  
10                  coverage.

11          (c) CONTRACTS WITH DISEASE MANAGEMENT ORGA-  
12          NIZATIONS.—

13               (1) IN GENERAL.—The Secretary of Health and  
14               Human Services shall carry out the project through  
15               contracts with up to three disease management orga-  
16               nizations. The Secretary shall not enter into such a  
17               contract with an organization unless the organiza-  
18               tion demonstrates that it can produce improved  
19               health outcomes and reduce aggregate medicare ex-  
20               penditures consistent with paragraph (2).

21               (2) CONTRACT PROVISIONS.—Under such  
22               contracts—

23                   (A) such an organization shall be required  
24                   to provide for prescription drug coverage de-  
25                   scribed in subsection (b)(2)(B);

1 (B) such an organization shall be paid a  
2 fee negotiated and established by the Secretary  
3 in a manner so that (taking into account sav-  
4 ings in expenditures under parts A and B of  
5 the medicare program under title XVIII of the  
6 Social Security Act) there will be a net reduc-  
7 tion in expenditures under the medicare pro-  
8 gram as a result of the project; and

9 (C) such an organization shall guarantee,  
10 through an appropriate arrangement with a re-  
11 insurance company or otherwise, the net reduc-  
12 tion in expenditures described in subparagraph  
13 (B).

14 (3) PAYMENTS.—Payments to such organiza-  
15 tions shall be made in appropriate proportion from  
16 the Trust Funds established under title XVIII of the  
17 Social Security Act.

18 (d) APPLICATION OF MEDIGAP PROTECTIONS TO  
19 DEMONSTRATION PROJECT ENROLLEES.—(1) Subject to  
20 paragraph (2), the provisions of section 1882(s)(3) (other  
21 than clauses (i) through (iv) of subparagraph (B)) and  
22 1882(s)(4) of the Social Security Act shall apply to enroll-  
23 ment (and termination of enrollment) in the demonstra-  
24 tion project under this section, in the same manner as they  
25 apply to enrollment (and termination of enrollment) with

1 a Medicare+Choice organization in a Medicare+Choice  
2 plan.

3 (2) In applying paragraph (1)—

4 (A) any reference in clause (v) or (vi) of section  
5 1882(s)(3)(B) of such Act to 12 months is deemed  
6 a reference to the period of the demonstration  
7 project; and

8 (B) the notification required under section  
9 1882(s)(3)(D) of such Act shall be provided in a  
10 manner specified by the Secretary of Health and  
11 Human Services.

12 (e) DURATION.—The project shall last for not longer  
13 than 3 years.

14 (f) WAIVER.—The Secretary of Health and Human  
15 Services shall waive such provisions of title XVIII of the  
16 Social Security Act as may be necessary to provide for  
17 payment for services under the project in accordance with  
18 subsection (c)(3).

19 (g) REPORT.—The Secretary of Health and Human  
20 Services shall submit to Congress an interim report on the  
21 project not later than 2 years after the date it is first im-  
22 plemented and a final report on the project not later than  
23 6 months after the date of its completion. Such reports  
24 shall include information on the impact of the project on

1 costs and health outcomes and recommendations on the  
2 cost-effectiveness of extending or expanding the project.

3 **SEC. 122. CANCER PREVENTION AND TREATMENT DEM-**  
4 **ONSTRATION FOR ETHNIC AND RACIAL MI-**  
5 **NORITIES.**

6 (a) DEMONSTRATION.—

7 (1) IN GENERAL.—The Secretary of Health and  
8 Human Services (in this section referred to as the  
9 “Secretary”) shall conduct demonstration projects  
10 (in this section referred to as “demonstration  
11 projects”) for the purpose of developing models and  
12 evaluating methods that—

13 (A) improve the quality of items and serv-  
14 ices provided to target individuals in order to  
15 facilitate reduced disparities in early detection  
16 and treatment of cancer;

17 (B) improve clinical outcomes, satisfaction,  
18 quality of life, and appropriate use of medicare-  
19 covered services and referral patterns among  
20 those target individuals with cancer;

21 (C) eliminate disparities in the rate of pre-  
22 ventive cancer screening measures, such as pap  
23 smears and prostate cancer screenings, among  
24 target individuals; and

1 (D) promote collaboration with community-  
2 based organizations to ensure cultural com-  
3 petency of health care professionals and lin-  
4 guistic access for persons with limited English  
5 proficiency.

6 (2) TARGET INDIVIDUAL DEFINED.—In this  
7 section, the term “target individual” means an indi-  
8 vidual of a racial and ethnic minority group, as de-  
9 fined by section 1707 of the Public Health Service  
10 Act, who is entitled to benefits under part A, and  
11 enrolled under part B, of title XVIII of the Social  
12 Security Act.

13 (b) PROGRAM DESIGN.—

14 (1) INITIAL DESIGN.—Not later than 1 year  
15 after the date of the enactment of this Act, the Sec-  
16 retary shall evaluate best practices in the private  
17 sector, community programs, and academic research  
18 of methods that reduce disparities among individuals  
19 of racial and ethnic minority groups in the preven-  
20 tion and treatment of cancer and shall design the  
21 demonstration projects based on such evaluation.

22 (2) NUMBER AND PROJECT AREAS.—Not later  
23 than 2 years after the date of the enactment of this  
24 Act, the Secretary shall implement at least nine  
25 demonstration projects, including the following:



1 (A) Two projects for each of the four fol-  
2 lowing major racial and ethnic minority groups:

3 (i) American Indians, including Alas-  
4 ka Natives, Eskimos, and Aleuts.

5 (ii) Asian Americans and Pacific Is-  
6 landers.

7 (iii) Blacks.

8 (iv) Hispanics.

9 The two projects must target different ethnic  
10 subpopulations.

11 (B) One project within the Pacific Islands.

12 (C) At least one project each in a rural  
13 area and inner-city area.

14 (3) EXPANSION OF PROJECTS; IMPLEMENTA-  
15 TION OF DEMONSTRATION PROJECT RESULTS.—If  
16 the initial report under subsection (c) contains an  
17 evaluation that demonstration projects—

18 (A) reduce expenditures under the medi-  
19 care program under title XVIII of the Social  
20 Security Act; or

21 (B) do not increase expenditures under the  
22 medicare program and reduce racial and ethnic  
23 health disparities in the quality of health care  
24 services provided to target individuals and in-

1           crease satisfaction of beneficiaries and health  
2           care providers;  
3       the Secretary shall continue the existing demonstra-  
4       tion projects and may expand the number of dem-  
5       onstration projects.

6       (c) REPORT TO CONGRESS.—

7           (1) IN GENERAL.—Not later than 2 years after  
8       the date the Secretary implements the initial dem-  
9       onstration projects, and biannually thereafter, the  
10      Secretary shall submit to Congress a report regard-  
11      ing the demonstration projects.

12          (2) CONTENTS OF REPORT.—Each report under  
13      paragraph (1) shall include the following:

14            (A) A description of the demonstration  
15      projects.

16            (B) An evaluation of—

17               (i) the cost-effectiveness of the dem-  
18      onstration projects;

19               (ii) the quality of the health care serv-  
20      ices provided to target individuals under  
21      the demonstration projects; and

22               (iii) beneficiary and health care pro-  
23      vider satisfaction under the demonstration  
24      projects.

1 (C) Any other information regarding the  
2 demonstration projects that the Secretary de-  
3 termines to be appropriate.

4 (d) WAIVER AUTHORITY.—The Secretary shall waive  
5 compliance with the requirements of title XVIII of the So-  
6 cial Security Act to such extent and for such period as  
7 the Secretary determines is necessary to conduct dem-  
8 onstration projects.

9 (e) FUNDING.—

10 (1) DEMONSTRATION PROJECTS.—

11 (A) STATE PROJECTS.—Except as provided  
12 in subparagraph (B), the Secretary shall pro-  
13 vide for the transfer from the Federal Hospital  
14 Insurance Trust Fund and the Federal Supple-  
15 mentary Insurance Trust Fund under title  
16 XVIII of the Social Security Act, in such pro-  
17 portions as the Secretary determines to be ap-  
18 propriate, of such funds as are necessary for  
19 the costs of carrying out the demonstration  
20 projects.

21 (B) TERRITORY PROJECTS.—In the case of  
22 a demonstration project described in subsection  
23 (b)(2)(B), amounts shall be available only as  
24 provided in any Federal law making appropria-  
25 tions for the territories.

1           (2) LIMITATION.—In conducting demonstration  
2       projects, the Secretary shall ensure that the aggregate  
3       payments made by the Secretary do not exceed  
4       the sum of the amount which the Secretary would  
5       have paid under the program for the prevention and  
6       treatment of cancer if the demonstration projects  
7       were not implemented, plus \$25,000,000.

8   **SEC. 123. STUDY ON MEDICARE COVERAGE OF ROUTINE**  
9                           **THYROID SCREENING.**

10       (a) STUDY.—The Secretary of Health and Human  
11   Services shall request the National Academy of Sciences,  
12   and as appropriate in conjunction with the United States  
13   Preventive Services Task Force, to conduct a study on the  
14   addition of coverage of routine thyroid screening using a  
15   thyroid stimulating hormone test as a preventive benefit  
16   provided to medicare beneficiaries under title XVIII of the  
17   Social Security Act for some or all medicare beneficiaries.  
18   In conducting the study, the Academy shall consider the  
19   short-term and long-term benefits, and costs to the medi-  
20   care program, of such addition.

21       (b) REPORT.—Not later than 2 years after the date  
22   of the enactment of this Act, the Secretary of Health and  
23   Human Services shall submit a report on the findings of  
24   the study conducted under subsection (a) to the Com-  
25   mittee on Ways and Means and the Committee on Com-

1 merce of the House of Representatives and the Committee  
2 on Finance of the Senate.

3 **SEC. 124. MEDPAC STUDY ON CONSUMER COALITIONS.**

4 (a) STUDY.—The Medicare Payment Advisory Com-  
5 mission shall conduct a study that examines the use of  
6 consumer coalitions in the marketing of Medicare+Choice  
7 plans under the medicare program under title XVIII of  
8 the Social Security Act. The study shall examine—

9 (1) the potential for increased efficiency in the  
10 medicare program through greater beneficiary  
11 knowledge of their health care options, decreased  
12 marketing costs of Medicare+Choice organizations,  
13 and creation of a group market;

14 (2) the implications of Medicare+Choice plans  
15 and medicare supplemental policies (under section  
16 1882 of the Social Security Act (42 U.S.C. 1395ss))  
17 offering medicare beneficiaries in the same geo-  
18 graphic location different benefits and premiums  
19 based on their affiliation with a consumer coalition;

20 (3) how coalitions should be governed, how they  
21 should be accountable to the Secretary of Health  
22 and Human Services, and how potential conflicts of  
23 interest in the activities of consumer coalitions  
24 should be avoided; and

25 (4) how such coalitions should be funded.

1       (b) REPORT.—Not later than 1 year after the date  
2 of the enactment of this Act, the Commission shall submit  
3 to Congress a report on the study conducted under sub-  
4 section (a). The report shall include a recommendation on  
5 whether and how a demonstration project might be con-  
6 ducted for the operation of consumer coalitions under the  
7 medicare program.

8       (c) CONSUMER COALITION DEFINED.—For purposes  
9 of this section, the term “consumer coalition” means a  
10 nonprofit, community-based group of organizations that—

11           (1) provides information to medicare bene-  
12 ficiaries about their health care options under the  
13 medicare program; and

14           (2) negotiates benefits and premiums for medi-  
15 care beneficiaries who are members or otherwise af-  
16 filiated with the group of organizations with  
17 Medicare+Choice organizations offering  
18 Medicare+Choice plans, issuers of medicare supple-  
19 mental policies, issuers of long-term care coverage,  
20 and pharmacy benefit managers.

1 **SEC. 125. STUDY ON LIMITATION ON STATE PAYMENT FOR**  
2 **MEDICARE COST-SHARING AFFECTING AC-**  
3 **CESS TO SERVICES FOR QUALIFIED MEDI-**  
4 **CARE BENEFICIARIES.**

5 (a) IN GENERAL.—The Secretary of Health and  
6 Human Services shall conduct a study to determine if ac-  
7 cess to certain services (including mental health services)  
8 for qualified medicare beneficiaries has been affected by  
9 limitations on a State’s payment for medicare cost-sharing  
10 for such beneficiaries under section 1902(n) of the Social  
11 Security Act (42 U.S.C. 1396a(n)). As part of such study,  
12 the Secretary shall analyze the effect of such payment lim-  
13 itation on providers who serve a disproportionate share of  
14 such beneficiaries.

15 (b) REPORT.—Not later than 1 year after the date  
16 of the enactment of this Act, the Secretary shall submit  
17 to Congress a report on the study under subsection (a).  
18 The report shall include recommendations regarding any  
19 changes that should be made to the State payment limits  
20 under section 1902(n) for qualified medicare beneficiaries  
21 to ensure appropriate access to services.

22 **SEC. 126. STUDIES ON PREVENTIVE INTERVENTIONS IN**  
23 **PRIMARY CARE FOR OLDER AMERICANS.**

24 (a) STUDIES.—The Secretary of Health and Human  
25 Services, acting through the United States Preventive  
26 Services Task Force, shall conduct a series of studies de-

1 signed to identify preventive interventions that can be de-  
2 livered in the primary care setting and that are most valu-  
3 able to older Americans.

4 (b) MISSION STATEMENT.—The mission statement of  
5 the United States Preventive Services Task Force is  
6 amended to include the evaluation of services that are of  
7 particular relevance to older Americans.

8 (c) REPORT.—Not later than 1 year after the date  
9 of the enactment of this Act, and annually thereafter, the  
10 Secretary of Health and Human Services shall submit to  
11 Congress a report on the conclusions of the studies con-  
12 ducted under subsection (a), together with recommenda-  
13 tions for such legislation and administrative actions as the  
14 Secretary considers appropriate.

15 **SEC. 127. MEDPAC STUDY AND REPORT ON MEDICARE COV-**  
16 **ERAGE OF CARDIAC AND PULMONARY REHA-**  
17 **BILITATION THERAPY SERVICES.**

18 (a) STUDY.—

19 (1) IN GENERAL.—The Medicare Payment Ad-  
20 visory Commission shall conduct a study on coverage  
21 of cardiac and pulmonary rehabilitation therapy  
22 services under the medicare program under title  
23 XVIII of the Social Security Act.



1           (2) FOCUS.—In conducting the study under  
2       paragraph (1), the Commission shall focus on the  
3       appropriate—

4           (A) qualifying diagnoses required for cov-  
5       erage of cardiac and pulmonary rehabilitation  
6       therapy services;

7           (B) level of physician direct involvement  
8       and supervision in furnishing such services; and

9           (C) level of reimbursement for such serv-  
10      ices.

11       (b) REPORT.—Not later than 18 months after the  
12      date of the enactment of this Act, the Commission shall  
13      submit to Congress a report on the study conducted under  
14      subsection (a) together with such recommendations for  
15      legislation and administrative action as the Commission  
16      determines appropriate.

17      **SEC. 128. LIFESTYLE MODIFICATION PROGRAM DEM-**  
18                                   **ONSTRATION.**

19       (a) IN GENERAL.—The Secretary of Health and  
20      Human Services shall carry out the demonstration project  
21      known as the Lifestyle Modification Program Demonstra-  
22      tion, as described in the Health Care Financing Adminis-  
23      tration Memorandum of Understanding entered into on  
24      November 13, 2000, and as subsequently modified, (in

1 this section referred to as the “project”) in accordance  
2 with the following requirements:

3 (1) The project shall include no fewer than  
4 1,800 medicare beneficiaries who complete under the  
5 project the entire course of treatment under the  
6 Lifestyle Modification Program.

7 (2) The project shall be conducted over a course  
8 of 4 years.

9 (b) STUDY ON COST-EFFECTIVENESS.—

10 (1) STUDY.—The Secretary shall conduct a  
11 study on the cost-effectiveness of the Lifestyle Modi-  
12 fication Program as conducted under the project. In  
13 determining whether such Program is cost-effective,  
14 the Secretary shall determine (using a control group  
15 under a matched paired experimental design) wheth-  
16 er expenditures incurred for medicare beneficiaries  
17 enrolled under the project exceed expenditures for  
18 the control group of medicare beneficiaries with  
19 similar health conditions who are not enrolled under  
20 the project.

21 (2) REPORTS.—

22 (A) INITIAL REPORT.—Not later than 1  
23 year after the date on which 900 medicare  
24 beneficiaries have completed the entire course  
25 of treatment under the Lifestyle Modification

1           Program under the project, the Secretary shall  
 2           submit to Congress an initial report on the  
 3           study conducted under paragraph (1).

4                   (B) FINAL REPORT.—Not later than 1 year  
 5           after the date on which 1,800 medicare bene-  
 6           ficiaries have completed the entire course of  
 7           treatment under such Program under the  
 8           project, the Secretary shall submit to Congress  
 9           a final report on the study conducted under  
 10          paragraph (1).

11   **TITLE II—RURAL HEALTH CARE**  
 12           **IMPROVEMENTS**  
 13           **Subtitle A—Critical Access**  
 14           **Hospital Provisions**

15   **SEC. 201. CLARIFICATION OF NO BENEFICIARY COST-SHAR-**  
 16           **ING FOR CLINICAL DIAGNOSTIC LABORA-**  
 17           **TORY TESTS FURNISHED BY CRITICAL AC-**  
 18           **CESS HOSPITALS.**

19           (a) PAYMENT CLARIFICATION.—Section 1834(g) (42  
 20   U.S.C. 1395m(g)) is amended by adding at the end the  
 21   following new paragraph:

22                   “(4) NO BENEFICIARY COST-SHARING FOR  
 23           CLINICAL DIAGNOSTIC LABORATORY SERVICES.—No  
 24           coinsurance, deductible, copayment, or other cost-  
 25           sharing otherwise applicable under this part shall

1       apply with respect to clinical diagnostic laboratory  
2       services furnished as an outpatient critical access  
3       hospital service. Nothing in this title shall be con-  
4       strued as providing for payment for clinical diag-  
5       nostic laboratory services furnished as part of out-  
6       patient critical access hospital services, other than  
7       on the basis described in this subsection.”.

8       (b) TECHNICAL AND CONFORMING AMENDMENTS.—

9               (1) Paragraphs (1)(D)(i) and (2)(D)(i) of sec-  
10       tion 1833(a) (42 U.S.C. 1395l(a)) are each amended  
11       by striking “or which are furnished on an outpatient  
12       basis by a critical access hospital”.

13              (2) Section 403(d)(2) of BBRA (113 Stat.  
14       1501A–371) is amended by striking “The amend-  
15       ment made by subsection (a) shall apply” and in-  
16       serting “Paragraphs (1) through (3) of section  
17       1834(g) of the Social Security Act (as amended by  
18       paragraph (1)) apply”.

19       (c) EFFECTIVE DATES.—The amendment made—

20              (1) by subsection (a) shall apply to services fur-  
21       nished on or after the date of the enactment of  
22       BBRA;

23              (2) by subsection (b)(1) shall apply as if in-  
24       cluded in the enactment of section 403(e)(1) of  
25       BBRA (113 Stat. 1501A–371); and

1           (3) by subsection (b)(2) shall apply as if in-  
 2           cluded in the enactment of section 403(d)(2) of  
 3           BBRA (113 Stat. 1501A–371).

4   **SEC. 202. ASSISTANCE WITH FEE SCHEDULE PAYMENT FOR**  
 5                   **PROFESSIONAL SERVICES UNDER ALL-INCLU-**  
 6                   **SIVE RATE.**

7           (a) IN GENERAL.—Section 1834(g)(2)(B) (42 U.S.C.  
 8   1395m(g)(2)(B)) is amended by inserting “115 percent  
 9   of” before “such amounts”.

10          (b) EFFECTIVE DATE.—The amendment made by  
 11   subsection (a) shall apply with respect to items and serv-  
 12   ices furnished on or after July 1, 2001.

13   **SEC. 203. EXEMPTION OF CRITICAL ACCESS HOSPITAL**  
 14                   **SWING BEDS FROM SNF PPS.**

15          (a) IN GENERAL.—Section 1888(e)(7) (42 U.S.C.  
 16   1395yy(e)(7)) is amended—

17           (1) in the heading, by striking “TRANSITION  
 18   FOR” and inserting “TREATMENT OF”;

19           (2) in subparagraph (A), by striking “IN GEN-  
 20   ERAL.—The” and inserting “TRANSITION.—Subject  
 21   to subparagraph (C), the”;

22           (3) in subparagraph (A), by inserting “(other  
 23   than critical access hospitals)” after “facilities de-  
 24   scribed in subparagraph (B)”;

1           (4) in subparagraph (B), by striking “, for  
2       which payment” and all that follows before the pe-  
3       riod; and

4           (5) by adding at the end the following new sub-  
5       paragraph:

6                       “(C) EXEMPTION FROM PPS OF SWING-  
7       BED SERVICES FURNISHED IN CRITICAL ACCESS  
8       HOSPITALS.—The prospective payment system  
9       established under this subsection shall not  
10      apply to services furnished by a critical access  
11      hospital pursuant to an agreement under sec-  
12      tion 1883.”.

13       (b) PAYMENT ON A REASONABLE COST BASIS FOR  
14      SWING BED SERVICES FURNISHED BY CRITICAL ACCESS  
15      HOSPITALS.—Section 1883(a) (42 U.S.C. 1395tt(a)) is  
16      amended—

17           (1) in paragraph (2)(A), by inserting “(other  
18      than a critical access hospital)” after “any hospital”;  
19      and

20           (2) by adding at the end the following new  
21      paragraph:

22           “(3) Notwithstanding any other provision of this title,  
23      a critical access hospital shall be paid for covered skilled  
24      nursing facility services furnished under an agreement en-  
25      tered into under this section on the basis of the reasonable

1 costs of such services (as determined under section  
2 1861(v)).”.

3 (c) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply to cost reporting periods beginning  
5 on or after the date of the enactment of this Act.

6 **SEC. 204. PAYMENT IN CRITICAL ACCESS HOSPITALS FOR**  
7 **EMERGENCY ROOM ON-CALL PHYSICIANS.**

8 (a) IN GENERAL.—Section 1834(g) (42 U.S.C.  
9 1395m(g)), as amended by section 201(a), is further  
10 amended by adding at the end the following new para-  
11 graph:

12 “(5) COVERAGE OF COSTS FOR EMERGENCY  
13 ROOM ON-CALL PHYSICIANS.—In determining the  
14 reasonable costs of outpatient critical access hospital  
15 services under paragraphs (1) and (2)(A), the Sec-  
16 retary shall recognize as allowable costs, amounts  
17 (as defined by the Secretary) for reasonable com-  
18 pensation and related costs for emergency room phy-  
19 sicians who are on-call (as defined by the Secretary)  
20 but who are not present on the premises of the crit-  
21 ical access hospital involved, and are not otherwise  
22 furnishing physicians’ services and are not on-call at  
23 any other provider or facility.”.

1 (b) EFFECTIVE DATE.—The amendment made by  
 2 subsection (a) shall apply to cost reporting periods begin-  
 3 ning on or after October 1, 2001.

4 **SEC. 205. TREATMENT OF AMBULANCE SERVICES FUR-**  
 5 **NISHED BY CERTAIN CRITICAL ACCESS HOS-**  
 6 **PITALS.**

7 (a) IN GENERAL.—Section 1834(l) (42 U.S.C.  
 8 1395m(l)) is amended by adding at the end the following  
 9 new paragraph:

10 “(8) SERVICES FURNISHED BY CRITICAL AC-  
 11 CESS HOSPITALS.—Notwithstanding any other provi-  
 12 sion of this subsection, the Secretary shall pay the  
 13 reasonable costs incurred in furnishing ambulance  
 14 services if such services are furnished—

15 “(A) by a critical access hospital (as de-  
 16 fined in section 1861(mm)(1)), or

17 “(B) by an entity that is owned and oper-  
 18 ated by a critical access hospital,

19 but only if the critical access hospital or entity is the  
 20 only provider or supplier of ambulance services that  
 21 is located within a 35-mile drive of such critical ac-  
 22 cess hospital.”.

23 (b) CONFORMING AMENDMENT.—Section  
 24 1833(a)(1)(R) (42 U.S.C. 1395l(a)(1)(R)) is amended—



1 (1) by striking “ambulance service,” and insert-  
2 ing “ambulance services, (i)”; and

3 (2) by inserting before the comma at the end  
4 the following: “and (ii) with respect to ambulance  
5 services described in section 1834(l)(8), the amounts  
6 paid shall be the amounts determined under section  
7 1834(g) for outpatient critical access hospital serv-  
8 ices”.

9 (c) EFFECTIVE DATE.—The amendments made by  
10 this section shall apply to services furnished on or after  
11 the date of the enactment of this Act.

12 **SEC. 206. GAO STUDY ON CERTAIN ELIGIBILITY REQUIRE-**  
13 **MENTS FOR CRITICAL ACCESS HOSPITALS.**

14 (a) STUDY.—The Comptroller General of the United  
15 States shall conduct a study on the eligibility requirements  
16 for critical access hospitals under section 1820(c) of the  
17 Social Security Act (42 U.S.C. 1395i–4(c)) with respect  
18 to limitations on average length of stay and number of  
19 beds in such a hospital, including an analysis of—

20 (1) the feasibility of having a distinct part unit  
21 as part of a critical access hospital for purposes of  
22 the medicare program under title XVIII of such Act;  
23 and

24 (2) the effect of seasonal variations in patient  
25 admissions on critical access hospital eligibility re-

1       quirements with respect to limitations on average  
2       annual length of stay and number of beds.

3       (b) REPORT.—Not later than 1 year after the date  
4 of the enactment of this Act, the Comptroller General shall  
5 submit to Congress a report on the study conducted under  
6 subsection (a) together with recommendations  
7 regarding—

8           (1) whether distinct part units should be per-  
9       mitted as part of a critical access hospital under the  
10      medicare program;

11          (2) if so permitted, the payment methodologies  
12      that should apply with respect to services provided  
13      by such units;

14          (3) whether, and to what extent, such units  
15      should be included in or excluded from the bed limits  
16      applicable to critical access hospitals under the  
17      medicare program; and

18          (4) any adjustments to such eligibility require-  
19      ments to account for seasonal variations in patient  
20      admissions.

## 1     **Subtitle B—Other Rural Hospitals** 2                     **Provisions**

### 3     **SEC. 211. TREATMENT OF RURAL DISPROPORTIONATE** 4                     **SHARE HOSPITALS.**

5             (a) APPLICATION OF UNIFORM THRESHOLD.—Sec-  
6     tion 1886(d)(5)(F)(v) (42 U.S.C. 1395ww(d)(5)(F)(v)) is  
7     amended—

8                 (1) in subclause (II), by inserting “(or 15 per-  
9             cent, for discharges occurring on or after April 1,  
10            2001)” after “30 percent”;

11                (2) in subclause (III), by inserting “(or 15 per-  
12             cent, for discharges occurring on or after April 1,  
13             2001)” after “40 percent”; and

14                (3) in subclause (IV), by inserting “(or 15 per-  
15             cent, for discharges occurring on or after April 1,  
16             2001)” after “45 percent”.

17             (b) ADJUSTMENT OF PAYMENT FORMULAS.—

18                (1) SOLE COMMUNITY HOSPITALS.—Section  
19     1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is  
20     amended—

21                     (A) in clause (iv)(VI), by inserting after  
22             “10 percent” the following: “or, for discharges  
23             occurring on or after April 1, 2001, is equal to  
24             the percent determined in accordance with  
25             clause (x)”; and

1 (B) by adding at the end the following new  
2 clause:

3 “(x) For purposes of clause (iv)(VI) (relating to sole  
4 community hospitals), in the case of a hospital for a cost  
5 reporting period with a disproportionate patient percent-  
6 age (as defined in clause (vi)) that—

7 “(I) is less than 19.3, the disproportionate  
8 share adjustment percentage is determined in ac-  
9 cordance with the following formula:  $(P-15)(.65) +$   
10  $2.5$ ;

11 “(II) is equal to or exceeds 19.3, but is less  
12 than 30.0, such adjustment percentage is equal to  
13 5.25 percent; or

14 “(III) is equal to or exceeds 30, such adjust-  
15 ment percentage is equal to 10 percent,

16 where ‘P’ is the hospital’s disproportionate patient per-  
17 centage (as defined in clause (vi)).”.

18 (2) RURAL REFERRAL CENTERS.—Such section  
19 is further amended—

20 (A) in clause (iv)(V), by inserting after  
21 “clause (viii)” the following: “or, for discharges  
22 occurring on or after April 1, 2001, is equal to  
23 the percent determined in accordance with  
24 clause (xi)”; and

1 (B) by adding at the end the following new  
2 clause:

3 “(xi) For purposes of clause (iv)(V) (relating to rural  
4 referral centers), in the case of a hospital for a cost report-  
5 ing period with a disproportionate patient percentage (as  
6 defined in clause (vi)) that—

7 “(I) is less than 19.3, the disproportionate  
8 share adjustment percentage is determined in ac-  
9 cordance with the following formula:  $(P-15)(.65) +$   
10  $2.5$ ;

11 “(II) is equal to or exceeds 19.3, but is less  
12 than 30.0, such adjustment percentage is equal to  
13 5.25 percent; or

14 “(III) is equal to or exceeds 30, such adjust-  
15 ment percentage is determined in accordance with  
16 the following formula:  $(P-30)(.6) + 5.25$ ,

17 where ‘P’ is the hospital’s disproportionate patient per-  
18 centage (as defined in clause (vi)).”.

19 (3) SMALL RURAL HOSPITALS GENERALLY.—  
20 Such section is further amended—

21 (A) in clause (iv)(III), by inserting after  
22 “4 percent” the following: “or, for discharges  
23 occurring on or after April 1, 2001, is equal to  
24 the percent determined in accordance with  
25 clause (xii)”; and

1 (B) by adding at the end the following new  
 2 clause:

3 “(xii) For purposes of clause (iv)(III) (relating to  
 4 small rural hospitals generally), in the case of a hospital  
 5 for a cost reporting period with a disproportionate patient  
 6 percentage (as defined in clause (vi)) that—

7 “(I) is less than 19.3, the disproportionate  
 8 share adjustment percentage is determined in ac-  
 9 cordance with the following formula:  $(P-15)(.65) +$   
 10  $2.5$ ; or

11 “(II) is equal to or exceeds 19.3, such adjust-  
 12 ment percentage is equal to 5.25 percent,  
 13 where ‘P’ is the hospital’s disproportionate patient per-  
 14 centage (as defined in clause (vi)).”.

15 (4) HOSPITALS THAT ARE BOTH SOLE COMMU-  
 16 NITY HOSPITALS AND RURAL REFERRAL CENTERS.—  
 17 Such section is further amended, in clause (iv)(IV),  
 18 by inserting after “clause (viii)” the following: “or,  
 19 for discharges occurring on or after April 1, 2001,  
 20 the greater of the percentages determined under  
 21 clause (x) or (xi)”.

22 (5) URBAN HOSPITALS WITH LESS THAN 100  
 23 BEDS.—Such section is further amended—

24 (A) in clause (iv)(II), by inserting after “5  
 25 percent” the following: “or, for discharges oc-

1 curring on or after April 1, 2001, is equal to  
 2 the percent determined in accordance with  
 3 clause (xiii)”; and

4 (B) by adding at the end the following new  
 5 clause:

6 “(xiii) For purposes of clause (iv)(II) (relating to  
 7 urban hospitals with less than 100 beds), in the case of  
 8 a hospital for a cost reporting period with a dispropor-  
 9 tionate patient percentage (as defined in clause (vi))  
 10 that—

11 “(I) is less than 19.3, the disproportionate  
 12 share adjustment percentage is determined in ac-  
 13 cordance with the following formula:  $(P-15)(.65) +$   
 14  $2.5$ ; or

15 “(II) is equal to or exceeds 19.3, such adjust-  
 16 ment percentage is equal to 5.25 percent,  
 17 where ‘P’ is the hospital’s disproportionate patient per-  
 18 centage (as defined in clause (vi)).”.

19 **SEC. 212. OPTION TO BASE ELIGIBILITY FOR MEDICARE DE-**  
 20 **PENDENT, SMALL RURAL HOSPITAL PRO-**  
 21 **GRAM ON DISCHARGES DURING TWO OF THE**  
 22 **THREE MOST RECENTLY AUDITED COST RE-**  
 23 **PORTING PERIODS.**

24 (a) IN GENERAL.—Section 1886(d)(5)(G)(iv)(IV)  
 25 (42 U.S.C. 1395ww(d)(5)(G)(iv)(IV)) is amended by in-

1 serting “, or two of the three most recently audited cost  
 2 reporting periods for which the Secretary has a settled  
 3 cost report,” after “1987”.

4 (b) EFFECTIVE DATE.—The amendment made by  
 5 this section shall apply with respect to cost reporting peri-  
 6 ods beginning on or after April 1, 2001.

7 **SEC. 213. EXTENSION OF OPTION TO USE REBASED TARGET**  
 8 **AMOUNTS TO ALL SOLE COMMUNITY HOS-**  
 9 **PITALS.**

10 (a) IN GENERAL.—Section 1886(b)(3)(I)(i) (42  
 11 U.S.C. 1395ww(b)(3)(I)(i)) is amended—

12 (1) in the matter preceding subclause (I), by  
 13 striking “that for its cost reporting period beginning  
 14 during 1999” and all that follows through “for such  
 15 target amount” and inserting “there shall be sub-  
 16 stituted for the amount otherwise determined under  
 17 subsection (d)(5)(D)(i), if such substitution results  
 18 in a greater amount of payment under this section  
 19 for the hospital”;

20 (2) in subclause (I), by striking “target amount  
 21 otherwise applicable” and all that follows through  
 22 “target amount’”)” and inserting “the amount other-  
 23 wise applicable to the hospital under subsection  
 24 (d)(5)(D)(i) (referred to in this clause as the ‘sub-  
 25 section (d)(5)(D)(i) amount’)”; and



1 (3) in each of subclauses (II) and (III), by  
 2 striking “subparagraph (C) target amount” and in-  
 3 serting “subsection (d)(5)(D)(i) amount”.

4 (b) EFFECTIVE DATE.—The amendments made by  
 5 this section shall take effect as if included in the enact-  
 6 ment of section 405 of BBRA (113 Stat. 1501A–372).

7 **SEC. 214. MEDPAC ANALYSIS OF IMPACT OF VOLUME ON**  
 8 **PER UNIT COST OF RURAL HOSPITALS WITH**  
 9 **PSYCHIATRIC UNITS.**

10 The Medicare Payment Advisory Commission, in its  
 11 study conducted pursuant to subsection (a) of section 411  
 12 of BBRA (113 Stat. 1501A–377), shall include—

13 (1) in such study an analysis of the impact of  
 14 volume on the per unit cost of rural hospitals with  
 15 psychiatric units; and

16 (2) in its report under subsection (b) of such  
 17 section a recommendation on whether special treat-  
 18 ment for such hospitals may be warranted.

19 **Subtitle C—Other Rural Provisions**

20 **SEC. 221. ASSISTANCE FOR PROVIDERS OF AMBULANCE**  
 21 **SERVICES IN RURAL AREAS.**

22 (a) TRANSITIONAL ASSISTANCE IN CERTAIN MILE-  
 23 AGE RATES.—Section 1834(l) (42 U.S.C. 1395m(l)) is  
 24 amended by adding at the end the following new para-  
 25 graph:

1           “(8) TRANSITIONAL ASSISTANCE FOR RURAL  
2 PROVIDERS.—In the case of ground ambulance serv-  
3 ices furnished on or after July 1, 2001, and before  
4 January 1, 2004, for which the transportation origi-  
5 nates in a rural area (as defined in section  
6 1886(d)(2)(D)) or in a rural census tract of a met-  
7 ropolitan statistical area (as determined under the  
8 most recent modification of the Goldsmith Modifica-  
9 tion, originally published in the Federal Register on  
10 February 27, 1992 (57 Fed. Reg. 6725)), the fee  
11 schedule established under this subsection shall pro-  
12 vide that, with respect to the payment rate for mile-  
13 age for a trip above 17 miles, and up to 50 miles,  
14 the rate otherwise established shall be increased by  
15 not less than ½ of the additional payment per mile  
16 established for the first 17 miles of such a trip origi-  
17 nating in a rural area.”.

18       (b) GAO STUDIES ON THE COSTS OF AMBULANCE  
19 SERVICES FURNISHED IN RURAL AREAS.—

20           (1) STUDY.—The Comptroller General of the  
21 United States shall conduct a study on each of the  
22 matters described in paragraph (2).

23           (2) MATTERS DESCRIBED.—The matters re-  
24 ferred to in paragraph (1) are the following:

1           (A) The cost of efficiently providing ambu-  
2           lance services for trips originating in rural  
3           areas, with special emphasis on collection of  
4           cost data from rural providers.

5           (B) The means by which rural areas with  
6           low population densities can be identified for  
7           the purpose of designating areas in which the  
8           cost of providing ambulance services would be  
9           expected to be higher than similar services pro-  
10          vided in more heavily populated areas because  
11          of low usage. Such study shall also include an  
12          analysis of the additional costs of providing am-  
13          bulance services in areas designated under the  
14          previous sentence.

15          (3) REPORT.—Not later than June 30, 2002,  
16          the Comptroller General shall submit to Congress a  
17          report on the results of the studies conducted under  
18          paragraph (1) and shall include recommendations on  
19          steps that should be taken to assure access to ambu-  
20          lance services in rural areas.

21          (c) ADJUSTMENT IN RURAL RATES.—In providing  
22          for adjustments under subparagraph (D) of section  
23          1834(l)(2) of the Social Security Act (42 U.S.C.  
24          1395m(l)(2)) for years beginning with 2004, the Secretary  
25          of Health and Human Services shall take into consider-

1 ation the recommendations contained in the report under  
 2 subsection (b)(2) and shall adjust the fee schedule pay-  
 3 ment rates under such section for ambulance services pro-  
 4 vided in low density rural areas based on the increased  
 5 cost (if any) of providing such services in such areas.

6 (d) EFFECTIVE DATE.—The amendment made by  
 7 subsection (a) shall apply to services furnished on or after  
 8 July 1, 2001. In applying such amendment to services fur-  
 9 nished on or after such date and before January 1, 2002,  
 10 the amount of the rate increase provided under such  
 11 amendment shall be equal to \$1.25 per mile.

12 **SEC. 222. PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT**  
 13 **SERVICES.**

14 (a) PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT  
 15 SERVICES.—Section 1842(b)(6)(C) (42 U.S.C.  
 16 1395u(b)(6)(C)) is amended—

17 (1) by striking “for such services provided be-  
 18 fore January 1, 2003,”; and

19 (2) by striking the semicolon at the end and in-  
 20 serting a comma.

21 (b) EFFECTIVE DATE.—The amendments made by  
 22 subsection (a) shall take effect on the date of the enact-  
 23 ment of this Act.

1 **SEC. 223. REVISION OF MEDICARE REIMBURSEMENT FOR**  
2 **TELEHEALTH SERVICES.**

3 (a) TIME LIMIT FOR BBA PROVISION.—Section  
4 4206(a) of BBA (42 U.S.C. 1395l note) is amended by  
5 striking “Not later than January 1, 1999” and inserting  
6 “For services furnished on and after January 1, 1999, and  
7 before October 1, 2001”.

8 (b) EXPANSION OF MEDICARE PAYMENT FOR TELE-  
9 HEALTH SERVICES.—Section 1834 (42 U.S.C. 1395m) is  
10 amended by adding at the end the following new sub-  
11 section:

12 “(m) PAYMENT FOR TELEHEALTH SERVICES.—

13 “(1) IN GENERAL.—The Secretary shall pay for  
14 telehealth services that are furnished via a tele-  
15 communications system by a physician (as defined in  
16 section 1861(r)) or a practitioner (described in sec-  
17 tion 1842(b)(18)(C)) to an eligible telehealth indi-  
18 vidual enrolled under this part notwithstanding that  
19 the individual physician or practitioner providing the  
20 telehealth service is not at the same location as the  
21 beneficiary. For purposes of the preceding sentence,  
22 in the case of any Federal telemedicine demonstra-  
23 tion program conducted in Alaska or Hawaii, the  
24 term ‘telecommunications system’ includes store-  
25 and-forward technologies that provide for the asyn-

1       chronous transmission of health care information in  
2       single or multimedia formats.

3               “(2) PAYMENT AMOUNT.—

4               “(A) DISTANT SITE.—The Secretary shall  
5       pay to a physician or practitioner located at a  
6       distant site that furnishes a telehealth service  
7       to an eligible telehealth individual an amount  
8       equal to the amount that such physician or  
9       practitioner would have been paid under this  
10      title had such service been furnished without  
11      the use of a telecommunications system.

12              “(B) FACILITY FEE FOR ORIGINATING  
13      SITE.—With respect to a telehealth service, sub-  
14      ject to section 1833(a)(1)(U), there shall be  
15      paid to the originating site a facility fee equal  
16      to—

17              “(i) for the period beginning on Octo-  
18      ber 1, 2001, and ending on December 31,  
19      2001, and for 2002, \$20; and

20              “(ii) for a subsequent year, the facil-  
21      ity fee specified in clause (i) or this clause  
22      for the preceding year increased by the  
23      percentage increase in the MEI (as defined  
24      in section 1842(i)(3)) for such subsequent  
25      year.

1           “(C) TELEPRESENTER NOT REQUIRED.—

2           Nothing in this subsection shall be construed as  
3           requiring an eligible telehealth individual to be  
4           presented by a physician or practitioner at the  
5           originating site for the furnishing of a service  
6           via a telecommunications system, unless it is  
7           medically necessary (as determined by the phy-  
8           sician or practitioner at the distant site).

9           “(3) LIMITATION ON BENEFICIARY CHARGES.—

10           “(A) PHYSICIAN AND PRACTITIONER.—

11           The provisions of section 1848(g) and subpara-  
12           graphs (A) and (B) of section 1842(b)(18) shall  
13           apply to a physician or practitioner receiving  
14           payment under this subsection in the same  
15           manner as they apply to physicians or practi-  
16           tioners under such sections.

17           “(B) ORIGINATING SITE.—The provisions  
18           of section 1842(b)(18) shall apply to originating  
19           sites receiving a facility fee in the same manner  
20           as they apply to practitioners under such sec-  
21           tion.

22           “(4) DEFINITIONS.—For purposes of this sub-  
23           section:

24           “(A) DISTANT SITE.—The term ‘distant  
25           site’ means the site at which the physician or

1 practitioner is located at the time the service is  
2 provided via a telecommunications system.

3 “(B) ELIGIBLE TELEHEALTH INDIVIDUAL.—The term ‘eligible telehealth indi-  
4 vidual’ means an individual enrolled under this  
5 part who receives a telehealth service furnished  
6 at an originating site.  
7

8 “(C) ORIGINATING SITE.—

9 “(i) IN GENERAL.—The term ‘origi-  
10 nating site’ means only those sites de-  
11 scribed in clause (ii) at which the eligible  
12 telehealth individual is located at the time  
13 the service is furnished via a telecommuni-  
14 cations system and only if such site is  
15 located—

16 “(I) in an area that is designated  
17 as a rural health professional shortage  
18 area under section 332(a)(1)(A) of  
19 the Public Health Service Act (42  
20 U.S.C. 254e(a)(1)(A));

21 “(II) in a county that is not in-  
22 cluded in a Metropolitan Statistical  
23 Area; or

24 “(III) from an entity that partici-  
25 pates in a Federal telemedicine dem-



1           onstration project that has been ap-  
2           proved by (or receives funding from)  
3           the Secretary of Health and Human  
4           Services as of December 31, 2000.

5           “(ii) SITES DESCRIBED.—The sites  
6           referred to in clause (i) are the following  
7           sites:

8                   “(I) The office of a physician or  
9                   practitioner.

10                   “(II) A critical access hospital  
11                   (as defined in section 1861(mm)(1)).

12                   “(III) A rural health clinic (as  
13                   defined in section 1861(aa)(s)).

14                   “(IV) A Federally qualified  
15                   health center (as defined in section  
16                   1861(aa)(4)).

17                   “(V) A hospital (as defined in  
18                   section 1861(e)).

19           “(D) PHYSICIAN.—The term ‘physician’  
20           has the meaning given that term in section  
21           1861(r).

22           “(E) PRACTITIONER.—The term ‘practi-  
23           tioner’ has the meaning given that term in sec-  
24           tion 1842(b)(18)(C).

25           “(F) TELEHEALTH SERVICE.—

“(i) IN GENERAL.—The term ‘telehealth service’ means professional consultations, office visits, and office psychiatry services (identified as of July 1, 2000, by HCPCS codes 99241–99275, 99201–99215, 90804–90809, and 90862 (and as subsequently modified by the Secretary)), and any additional service specified by the Secretary.

“(ii) YEARLY UPDATE.—The Secretary shall establish a process that provides, on an annual basis, for the addition or deletion of services (and HCPCS codes), as appropriate, to those specified in clause (i) for authorized payment under paragraph (1).”.

(c) CONFORMING AMENDMENT.—Section 1833(a)(1) (42 U.S.C. 1395l(1)), as amended by section 105(c), is further amended—

(1) by striking “and (T)” and inserting “(T)”;

and

(2) by inserting before the semicolon at the end the following: “, and (U) with respect to facility fees described in section 1834(m)(2)(B), the amounts

1       paid shall be 80 percent of the lesser of the actual  
2       charge or the amounts specified in such section”.

3       (d) STUDY AND REPORT ON ADDITIONAL COV-  
4       ERAGE.—

5           (1) STUDY.—The Secretary of Health and  
6       Human Services shall conduct a study to identify—

7           (A) settings and sites for the provision of  
8       telehealth services that are in addition to those  
9       permitted under section 1834(m) of the Social  
10      Security Act, as added by subsection (b);

11          (B) practitioners that may be reimbursed  
12      under such section for furnishing telehealth  
13      services that are in addition to the practitioners  
14      that may be reimbursed for such services under  
15      such section; and

16          (C) geographic areas in which telehealth  
17      services may be reimbursed that are in addition  
18      to the geographic areas where such services  
19      may be reimbursed under such section.

20          (2) REPORT.—Not later than 2 years after the  
21      date of the enactment of this Act, the Secretary  
22      shall submit to Congress a report on the study con-  
23      ducted under paragraph (1) together with such rec-  
24      ommendations for legislation that the Secretary de-  
25      termines are appropriate.

1 (e) EFFECTIVE DATE.—The amendments made by  
2 subsections (b) and (c) shall be effective for services fur-  
3 nished on or after October 1, 2001.

4 **SEC. 224. EXPANDING ACCESS TO RURAL HEALTH CLINICS.**

5 (a) IN GENERAL.—The matter in section 1833(f)  
6 (42 U.S.C. 1395l(f)) preceding paragraph (1) is amended  
7 by striking “rural hospitals” and inserting “hospitals”.

8 (b) EFFECTIVE DATE.—The amendment made by  
9 subsection (a) shall apply to services furnished on or after  
10 July 1, 2001.

11 **SEC. 225. MEDPAC STUDY ON LOW-VOLUME, ISOLATED**  
12 **RURAL HEALTH CARE PROVIDERS.**

13 (a) STUDY.—The Medicare Payment Advisory Com-  
14 mission shall conduct a study on the effect of low patient  
15 and procedure volume on the financial status of low-vol-  
16 ume, isolated rural health care providers participating in  
17 the medicare program under title XVIII of the Social Se-  
18 curity Act.

19 (b) REPORT.—Not later than 18 months after the  
20 date of the enactment of this Act, the Commission shall  
21 submit to Congress a report on the study conducted under  
22 subsection (a) indicating—

23 (1) whether low-volume, isolated rural health  
24 care providers are having, or may have, significantly  
25 decreased medicare margins or other financial dif-

1        difficulties resulting from any of the payment meth-  
2        odologies described in subsection (c);

3            (2) whether the status as a low-volume, isolated  
4        rural health care provider should be designated  
5        under the medicare program and any criteria that  
6        should be used to qualify for such a status; and

7            (3) any changes in the payment methodologies  
8        described in subsection (c) that are necessary to pro-  
9        vide appropriate reimbursement under the medicare  
10       program to low-volume, isolated rural health care  
11       providers (as designated pursuant to paragraph (2)).

12        (c) PAYMENT METHODOLOGIES DESCRIBED.—The  
13       payment methodologies described in this subsection are  
14       the following:

15            (1) The prospective payment system for hos-  
16        pital outpatient department services under section  
17        1833(t) of the Social Security Act (42 U.S.C.  
18        1395l(t)).

19            (2) The fee schedule for ambulance services  
20        under section 1834(l) of such Act (42 U.S.C.  
21        1395m(l)).

22            (3) The prospective payment system for inpa-  
23        tient hospital services under section 1886 of such  
24        Act (42 U.S.C. 1395ww).

1           (4) The prospective payment system for routine  
2           service costs of skilled nursing facilities under sec-  
3           tion 1888(e) of such Act (42 U.S.C. 1395yy(e)).

4           (5) The prospective payment system for home  
5           health services under section 1895 of such Act (42  
6           U.S.C. 1395fff).

7                   **TITLE III—PROVISIONS**  
8                   **RELATING TO PART A**  
9                   **Subtitle A—Inpatient Hospital**  
10                   **Services**

11   **SEC. 301. REVISION OF ACUTE CARE HOSPITAL PAYMENT**

12                   **UPDATE FOR 2001.**

13           (a) IN GENERAL.—Section 1886(b)(3)(B)(i) (42  
14   U.S.C. 1395ww(b)(3)(B)(i)) is amended—

15                   (1) in subclause (XVI), by striking “minus 1.1  
16           percentage points for hospitals (other than sole com-  
17           munity hospitals) in all areas, and the market bas-  
18           ket percentage increase for sole community hos-  
19           pitals,” and inserting “for hospitals in all areas,”;

20                   (2) in subclause (XVII)—

21                           (A) by striking “minus 1.1 percentage  
22           points” and inserting “minus 0.55 percentage  
23           points; and

24                           (B) by striking “and” at the end;

1           (3) by redesignating subclause (XVIII) as sub-  
2       clause (XIX);

3           (4) in subclause (XIX), as so redesignated, by  
4       striking “fiscal year 2003” and inserting “fiscal year  
5       2004”; and

6           (5) by inserting after subclause (XVII) the fol-  
7       lowing new subclause:

8           “(XVIII) for fiscal year 2003, the market bas-  
9       ket percentage increase minus 0.55 percentage  
10      points for hospitals in all areas, and”.

11      (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR  
12      2001.—Notwithstanding the amendment made by sub-  
13      section (a), for purposes of making payments for fiscal  
14      year 2001 for inpatient hospital services furnished by sub-  
15      section (d) hospitals (as defined in section 1886(d)(1)(B)  
16      of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)),  
17      the “applicable percentage increase” referred to in section  
18      1886(b)(3)(B)(i) of such Act (42 U.S.C.  
19      1395ww(b)(3)(B)(i))—

20           (1) for discharges occurring on or after October  
21      1, 2000, and before April 1, 2001, shall be deter-  
22      mined in accordance with subclause (XVI) of such  
23      section as in effect on the day before the date of the  
24      enactment of this Act; and

1           (2) for discharges occurring on or after April 1,  
2       2001, and before October 1, 2001, shall be equal  
3       to—

4           (A) the market basket percentage increase  
5       plus 1.1 percentage points for hospitals (other  
6       than sole community hospitals) in all areas; and

7           (B) the market basket percentage increase  
8       for sole community hospitals.

9       (c) CONSIDERATION OF PRICE OF BLOOD AND  
10      BLOOD PRODUCTS IN MARKET BASKET INDEX.—The  
11      Secretary of Health and Human Services shall, when next  
12      (after the date of the enactment of this Act) rebasing and  
13      revising the hospital market basket index (as defined in  
14      section 1886(b)(3)(B)(iii) of the Social Security Act (42  
15      U.S.C. 1395ww(b)(3)(B)(iii))), consider the prices of  
16      blood and blood products purchased by hospitals and de-  
17      termine whether those prices are adequately reflected in  
18      such index.

19      (d) MEDPAC STUDY AND REPORT REGARDING CER-  
20      TAIN HOSPITAL COSTS.—

21           (1) STUDY.—The Medicare Payment Advisory  
22      Commission shall conduct a study on—

23           (A) any increased costs incurred by sub-  
24      section (d) hospitals (as defined in paragraph

25      (1)(B) of section 1886(d) of the Social Security



1 Act (42 U.S.C. 1395ww(d))) in providing inpa-  
2 tient hospital services to medicare beneficiaries  
3 under title XVIII of such Act during the period  
4 beginning on October 1, 1983, and ending on  
5 September 30, 1999, that were attributable  
6 to—

7 (i) complying with new blood safety  
8 measure requirements; and

9 (ii) providing such services using new  
10 technologies;

11 (B) the extent to which the prospective  
12 payment system for such services under such  
13 section provides adequate and timely recogni-  
14 tion of such increased costs;

15 (C) the prospects for (and to the extent  
16 practicable, the magnitude of) cost increases  
17 that hospitals will incur in providing such serv-  
18 ices that are attributable to complying with new  
19 blood safety measure requirements and pro-  
20 viding such services using new technologies dur-  
21 ing the 10 years after the date of the enact-  
22 ment of this Act; and

23 (D) the feasibility and advisability of es-  
24 tablishing mechanisms under such payment sys-

1           tem to provide for more timely and accurate  
2           recognition of such cost increases in the future.

3           (2) CONSULTATION.—In conducting the study  
4           under this subsection, the Commission shall consult  
5           with representatives of the blood community,  
6           including—

7                   (A) hospitals;

8                   (B) organizations involved in the collection,  
9           processing, and delivery of blood; and

10                  (C) organizations involved in the develop-  
11           ment of new blood safety technologies.

12           (3) REPORT.—Not later than 1 year after the  
13           date of the enactment of this Act, the Commission  
14           shall submit to Congress a report on the study con-  
15           ducted under paragraph (1) together with such rec-  
16           ommendations for legislation and administrative ac-  
17           tion as the Commission determines appropriate.

18           (e) ADJUSTMENT FOR INPATIENT CASE MIX  
19           CHANGES.—

20           (1) IN GENERAL.—Section 1886(d)(3)(A) (42  
21           U.S.C. 1395ww(d)(3)(A)) is amended by adding at  
22           the end the following new clause:

23                   “(vi) Insofar as the Secretary determines that  
24           the adjustments under paragraph (4)(C)(i) for a  
25           previous fiscal year (or estimates that such adjust-

1       ments for a future fiscal year) did (or are likely to)  
 2       result in a change in aggregate payments under this  
 3       subsection during the fiscal year that are a result of  
 4       changes in the coding or classification of discharges  
 5       that do not reflect real changes in case mix, the Sec-  
 6       retary may adjust the average standardized amounts  
 7       computed under this paragraph for subsequent fiscal  
 8       years so as to eliminate the effect of such coding or  
 9       classification changes.”.

10           (2) EFFECTIVE DATE.—The amendment made  
 11       by paragraph (1) shall apply to discharges occurring  
 12       on or after October 1, 2001.

13       **SEC. 302. ADDITIONAL MODIFICATION IN TRANSITION FOR**  
 14                           **INDIRECT MEDICAL EDUCATION (IME) PER-**  
 15                           **CENTAGE ADJUSTMENT.**

16       (a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42  
 17       U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

18           (1) in subclause (V) by striking “and” at the  
 19       end;

20           (2) by redesignating subclause (VI) as sub-  
 21       clause (VII);

22           (3) in subclause (VII) as so redesignated, by  
 23       striking “2001” and inserting “2002”; and

24           (4) by inserting after subclause (V) the fol-  
 25       lowing new subclause:

1 “(VI) during fiscal year 2002, ‘c’ is equal  
2 to 1.6; and”.

3 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR  
4 2001.—Notwithstanding paragraph (5)(B)(ii)(V) of sec-  
5 tion 1886(d) of the Social Security Act (42 U.S.C.  
6 1395ww(d)(5)(B)(ii)(V)), for purposes of making pay-  
7 ments for subsection (d) hospitals (as defined in para-  
8 graph (1)(B) of such section) with indirect costs of med-  
9 ical education, the indirect teaching adjustment factor re-  
10 ferred to in paragraph (5)(B)(ii) of such section shall be  
11 determined, for discharges occurring on or after April 1,  
12 2001, and before October 1, 2001, as if “c” in paragraph  
13 (5)(B)(ii)(V) of such section equalled 1.66 rather than  
14 1.54.

15 (c) CONFORMING AMENDMENT RELATING TO DE-  
16 TERMINATION OF STANDARDIZED AMOUNT.—Section  
17 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is  
18 amended by inserting “or of section 302 of the Medicare,  
19 Medicaid, and SCHIP Benefits Improvement and Protec-  
20 tion Act of 2000” after “Balanced Budget Refinement Act  
21 of 1999”.

22 (d) CLERICAL AMENDMENTS.—Section  
23 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)), as amended  
24 by subsection (a), is further amended by moving the in-  
25 dentation of each of the following 2 ems to the left:

1 (1) Clauses (ii), (v), and (vi).

2 (2) Subclauses (I) (II), (III), (IV), (V), and  
3 (VII) of clause (ii).

4 (3) Subclauses (I) and (II) of clause (vi) and  
5 the flush sentence at the end of such clause.

6 **SEC. 303. DECREASE IN REDUCTIONS FOR DISPROPOR-**  
7 **TIONATE SHARE HOSPITAL (DSH) PAYMENTS.**

8 (a) IN GENERAL.—Section 1886(d)(5)(F)(ix) (42  
9 U.S.C. 1395ww(d)(5)(F)(ix)) is amended—

10 (1) in subclause (III), by striking “each of” and  
11 by inserting “and 2 percent, respectively” after “3  
12 percent”; and

13 (2) in subclause (IV), by striking “4 percent”  
14 and inserting “3 percent”.

15 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR  
16 2001.—Notwithstanding the amendment made by sub-  
17 section (a)(1), for purposes of making disproportionate  
18 share payments for subsection (d) hospitals (as defined  
19 in section 1886(d)(1)(B) of the Social Security Act (42  
20 U.S.C. 1395ww(d)(1)(B)) for fiscal year 2001, the addi-  
21 tional payment amount otherwise determined under clause  
22 (ii) of section 1886(d)(5)(F) of the Social Security Act  
23 (42 U.S.C. 1395ww(d)(5)(F))—

24 (1) for discharges occurring on or after October  
25 1, 2000, and before April 1, 2001, shall be adjusted

1 as provided by clause (ix)(III) of such section as in  
 2 effect on the day before the date of the enactment  
 3 of this Act; and

4 (2) for discharges occurring on or after April 1,  
 5 2001, and before October 1, 2001, shall, instead of  
 6 being reduced by 3 percent as provided by clause  
 7 (ix)(III) of such section as in effect after the date  
 8 of the enactment of this Act, be reduced by 1 per-  
 9 cent.

10 (c) CONFORMING AMENDMENTS RELATING TO DE-  
 11 TERMINATION OF STANDARDIZED AMOUNT.—Section  
 12 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)), is  
 13 amended—

14 (1) by striking “1989 or” and inserting  
 15 “1989,”; and

16 (2) by inserting “, or the enactment of section  
 17 303 of the Medicare, Medicaid, and SCHIP Benefits  
 18 Improvement and Protection Act of 2000” after  
 19 “Omnibus Budget Reconciliation Act of 1990”.

20 (d) TECHNICAL AMENDMENT.—

21 (1) IN GENERAL.—Section 1886(d)(5)(F)(i) (42  
 22 U.S.C. 1395ww(d)(5)(F)(i)) is amended by striking  
 23 “and before October 1, 1997,”.

1           (2) EFFECTIVE DATE.—The amendment made  
2       by paragraph (1) is effective as if included in the en-  
3       actment of BBA.

4       (e) REFERENCE TO CHANGES IN DSH FOR RURAL  
5   HOSPITALS.—For additional changes in the DSH pro-  
6   gram for rural hospitals, see section 211.

7   **SEC. 304. WAGE INDEX IMPROVEMENTS.**

8       (a) DURATION OF WAGE INDEX RECLASSIFICATION;  
9   USE OF 3-YEAR WAGE DATA.—Section 1886(d)(10)(D)  
10  (42 U.S.C. 1395ww(d)(10)(D)) is amended by adding at  
11  the end the following new clauses:

12       “(v) Any decision of the Board to reclassify a sub-  
13   section (d) hospital for purposes of the adjustment factor  
14   described in subparagraph (C)(i)(II) for fiscal year 2001  
15   or any fiscal year thereafter shall be effective for a period  
16   of 3 fiscal years, except that the Secretary shall establish  
17   procedures under which a subsection (d) hospital may  
18   elect to terminate such reclassification before the end of  
19   such period.

20       “(vi) Such guidelines shall provide that, in making  
21   decisions on applications for reclassification for the pur-  
22   poses described in clause (v) for fiscal year 2003 and any  
23   succeeding fiscal year, the Board shall base any compari-  
24   son of the average hourly wage for the hospital with the  
25   average hourly wage for hospitals in an area on—

1           “(I) an average of the average hourly wage  
 2           amount for the hospital from the most recently pub-  
 3           lished hospital wage survey data of the Secretary (as  
 4           of the date on which the hospital applies for reclassi-  
 5           fication) and such amount from each of the two im-  
 6           mediately preceding surveys; and

7           “(II) an average of the average hourly wage  
 8           amount for hospitals in such area from the most re-  
 9           cently published hospital wage survey data of the  
 10          Secretary (as of the date on which the hospital ap-  
 11          plies for reclassification) and such amount from each  
 12          of the two immediately preceding surveys.”.

13          (b) PROCESS TO PERMIT STATEWIDE WAGE INDEX  
 14          CALCULATION AND APPLICATION.—

15               (1) IN GENERAL.—The Secretary of Health and  
 16          Human Services shall establish a process (based on  
 17          the voluntary process utilized by the Secretary of  
 18          Health and Human Services under section 1848 of  
 19          the Social Security Act (42 U.S.C. 1395w-4) for  
 20          purposes of computing and applying a statewide geo-  
 21          graphic adjustment factor) under which an appro-  
 22          priate statewide entity may apply to have all the ge-  
 23          ographic areas in a State treated as a single geo-  
 24          graphic area for purposes of computing and applying  
 25          the area wage index under section 1886(d)(3)(E) of



1 such Act (42 U.S.C. 1395ww(d)(3)(E)). Such proc-  
 2 ess shall be established by October 1, 2001, for re-  
 3 classifications beginning in fiscal year 2003.

4 (2) PROHIBITION ON INDIVIDUAL HOSPITAL RE-  
 5 CLASSIFICATION.—Notwithstanding any other provi-  
 6 sion of law, if the Secretary applies a statewide geo-  
 7 graphic wage index under paragraph (1) with re-  
 8 spect to a State, any application submitted by a hos-  
 9 pital in that State under section 1886(d)(10) of the  
 10 Social Security Act (42 U.S.C. 1395ww(d)(10)) for  
 11 geographic reclassification shall not be considered.

12 (c) COLLECTION OF INFORMATION ON OCCUPA-  
 13 TIONAL MIX.—

14 (1) IN GENERAL.—The Secretary of Health and  
 15 Human Services shall provide for the collection of  
 16 data every 3 years on occupational mix for employ-  
 17 ees of each subsection (d) hospital (as defined in  
 18 section 1886(d)(1)(D) of the Social Security Act (42  
 19 U.S.C. 1395ww(d)(1)(D))) in the provision of inpa-  
 20 tient hospital services, in order to construct an occu-  
 21 pational mix adjustment in the hospital area wage  
 22 index applied under section 1886(d)(3)(E) of such  
 23 Act (42 U.S.C. 1395ww(d)(3)(E)).

24 (2) APPLICATION.—The third sentence of sec-  
 25 tion 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is

1       amended by striking “To the extent determined fea-  
 2       sible by the Secretary, such survey shall measure”  
 3       and inserting “Not less often than once every 3  
 4       years the Secretary (through such survey or other-  
 5       wise) shall measure”.

6               (3) EFFECTIVE DATE.—By not later than Sep-  
 7       tember 30, 2003, for application beginning October  
 8       1, 2004, the Secretary shall first complete—

9               (A) the collection of data under paragraph  
 10       (1); and

11              (B) the measurement under the third sen-  
 12       tence of section 1886(d)(3)(E), as amended by  
 13       paragraph (2).

14   **SEC. 305. PAYMENT FOR INPATIENT SERVICES OF REHA-**  
 15       **BILITATION HOSPITALS.**

16       (a) ASSISTANCE WITH ADMINISTRATIVE COSTS AS-  
 17       SOCIATED WITH COMPLETION OF PATIENT ASSESS-  
 18       MENT.—Section 1886(j)(3)(B) (42 U.S.C.  
 19       1395ww(j)(3)(B)) is amended by striking “98 percent”  
 20       and inserting “98 percent for fiscal year 2001 and 100  
 21       percent for fiscal year 2002”.

22       (b) ELECTION TO APPLY FULL PROSPECTIVE PAY-  
 23       MENT RATE WITHOUT PHASE-IN.—

24              (1) IN GENERAL.—Paragraph (1) of section  
 25       1886(j) (42 U.S.C. 1395ww(j)) is amended—

1 (A) in subparagraph (A), by inserting  
2 “other than a facility making an election under  
3 subparagraph (F)” before “in a cost reporting  
4 period”;

5 (B) in subparagraph (B), by inserting “or,  
6 in the case of a facility making an election  
7 under subparagraph (F), for any cost reporting  
8 period described in such subparagraph,” after  
9 “2002,”; and

10 (C) by adding at the end the following new  
11 subparagraph:

12 “(F) ELECTION TO APPLY FULL PROSPEC-  
13 TIVE PAYMENT SYSTEM.—A rehabilitation facil-  
14 ity may elect, not later than 30 days before its  
15 first cost reporting period for which the pay-  
16 ment methodology under this subsection applies  
17 to the facility, to have payment made to the fa-  
18 cility under this subsection under the provisions  
19 of subparagraph (B) (rather than subparagraph  
20 (A)) for each cost reporting period to which  
21 such payment methodology applies.”.

22 (2) CLARIFICATION.—Paragraph (3)(B) of such  
23 section is amended by inserting “but not taking into  
24 account any payment adjustment resulting from an

1 election permitted under paragraph (1)(F)” after  
 2 “paragraphs (4) and (6)”.

3 (c) EFFECTIVE DATE.—The amendments made by  
 4 this section take effect as if included in the enactment of  
 5 BBA.

6 **SEC. 306. PAYMENT FOR INPATIENT SERVICES OF PSY-**  
 7 **CHIATRIC HOSPITALS.**

8 With respect to hospitals described in clause (i) of  
 9 section 1886(d)(1)(B) of the Social Security Act (42  
 10 U.S.C. 1395ww(d)(1)(B)) and psychiatric units described  
 11 in the matter following clause (v) of such section, in mak-  
 12 ing incentive payments to such hospitals under section  
 13 1886(b)(1)(A) of such Act (42 U.S.C. 1395ww(b)(1)(A))  
 14 for cost reporting periods beginning on or after October  
 15 1, 2000, and before October 1, 2001, the Secretary of  
 16 Health and Human Services, in clause (ii) of such section,  
 17 shall substitute “3 percent” for “2 percent”.

18 **SEC. 307. PAYMENT FOR INPATIENT SERVICES OF LONG-**  
 19 **TERM CARE HOSPITALS.**

20 (a) INCREASED TARGET AMOUNTS AND CAPS FOR  
 21 LONG-TERM CARE HOSPITALS BEFORE IMPLEMENTA-  
 22 TION OF THE PROSPECTIVE PAYMENT SYSTEM.—

23 (1) IN GENERAL.—Section 1886(b)(3) (42  
 24 U.S.C. 1395ww(b)(3)) is amended—

1 (A) in subparagraph (H)(ii)(III), by insert-  
2 ing “subject to subparagraph (J),” after  
3 “2002,”; and

4 (B) by adding at the end the following new  
5 subparagraph:

6 “(J) For cost reporting periods beginning during fis-  
7 cal year 2001, for a hospital described in subsection  
8 (d)(1)(B)(iv)—

9 “(i) the limiting or cap amount otherwise deter-  
10 mined under subparagraph (H) shall be increased by  
11 2 percent; and

12 “(ii) the target amount otherwise determined  
13 under subparagraph (A) shall be increased by 25  
14 percent (subject to the limiting or cap amount deter-  
15 mined under subparagraph (H), as increased by  
16 clause (i)).”.

17 (2) APPLICATION.—The amendments made by  
18 subsection (a) and by section 122 of BBRA (113  
19 Stat. 1501A–331) shall not be taken into account in  
20 the development and implementation of the prospec-  
21 tive payment system under section 123 of BBRA  
22 (113 Stat. 1501A–331).

23 (b) IMPLEMENTATION OF PROSPECTIVE PAYMENT  
24 SYSTEM FOR LONG-TERM CARE HOSPITALS.—

1           (1) MODIFICATION OF REQUIREMENT.—In de-  
2       veloping the prospective payment system for pay-  
3       ment for inpatient hospital services provided in long-  
4       term care hospitals described in section  
5       1886(d)(1)(B)(iv) of the Social Security Act (42  
6       U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare  
7       program under title XVIII of such Act required  
8       under section 123 of BBRA, the Secretary of Health  
9       and Human Services shall examine the feasibility  
10      and the impact of basing payment under such a sys-  
11      tem on the use of existing (or refined) hospital diag-  
12      nosis-related groups (DRGs) that have been modi-  
13      fied to account for different resource use of long-  
14      term care hospital patients as well as the use of the  
15      most recently available hospital discharge data. The  
16      Secretary shall examine and may provide for appro-  
17      priate adjustments to the long-term hospital pay-  
18      ment system, including adjustments to DRG  
19      weights, area wage adjustments, geographic reclassi-  
20      fication, outliers, updates, and a disproportionate  
21      share adjustment consistent with section  
22      1886(d)(5)(F) of the Social Security Act (42 U.S.C.  
23      1395ww(d)(5)(F)).

24           (2) DEFAULT IMPLEMENTATION OF SYSTEM  
25      BASED ON EXISTING DRG METHODOLOGY.—If the

1 Secretary is unable to implement the prospective  
 2 payment system under section 123 of the BBRA by  
 3 October 1, 2002, the Secretary shall implement a  
 4 prospective payment system for such hospitals that  
 5 bases payment under such a system using existing  
 6 hospital diagnosis-related groups (DRGs), modified  
 7 where feasible to account for resource use of long-  
 8 term care hospital patients using the most recently  
 9 available hospital discharge data for such services  
 10 furnished on or after that date.

11 **Subtitle B—Adjustments to PPS**  
 12 **Payments for Skilled Nursing**  
 13 **Facilities**

14 **SEC. 311. ELIMINATION OF REDUCTION IN SKILLED NURS-**  
 15 **ING FACILITY (SNF) MARKET BASKET UP-**  
 16 **DATE IN 2001.**

17 (a) IN GENERAL.—Section 1888(e)(4)(E)(ii) (42  
 18 U.S.C. 1395yy(e)(4)(E)(ii)) is amended—

19 (1) by redesignating subclauses (II) and (III)  
 20 as subclauses (III) and (IV), respectively;

21 (2) in subclause (III), as so redesignated—

22 (A) by striking “each of fiscal years 2001  
 23 and 2002” and inserting “each of fiscal years  
 24 2002 and 2003”; and

1 (B) by striking “minus 1 percentage  
 2 point” and inserting “minus 0.5 percentage  
 3 points”; and

4 (3) by inserting after subclause (I) the fol-  
 5 lowing new subclause:

6 “(II) for fiscal year 2001, the  
 7 rate computed for the previous fiscal  
 8 year increased by the skilled nursing  
 9 facility market basket percentage  
 10 change for the fiscal year;”.

11 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR  
 12 2001.—Notwithstanding the amendments made by sub-  
 13 section (a), for purposes of making payments for covered  
 14 skilled nursing facility services under section 1888(e) of  
 15 the Social Security Act (42 U.S.C. 1395yy(e)) for fiscal  
 16 year 2001, the Federal per diem rate referred to in para-  
 17 graph (4)(E)(ii) of such section—

18 (1) for the period beginning on October 1,  
 19 2000, and ending on March 31, 2001, shall be the  
 20 rate determined in accordance with the law as in ef-  
 21 fect on the day before the date of the enactment of  
 22 this Act; and

23 (2) for the period beginning on April 1, 2001,  
 24 and ending on September 30, 2001, shall be the rate  
 25 that would have been determined under such section



1       if “plus 1 percentage point” had been substituted  
2       for “minus 1 percentage point” under subclause (II)  
3       of such paragraph (as in effect on the day before the  
4       date of the enactment of this Act).

5       (c) RELATION TO TEMPORARY INCREASE IN  
6 BBRA.—The increases provided under section 101 of  
7 BBRA (113 Stat. 1501A–325) shall be in addition to any  
8 increase resulting from the amendments made by sub-  
9 section (a).

10       (d) GAO REPORT ON ADEQUACY OF SNF PAYMENT  
11 RATES.—Not later than July 1, 2002, the Comptroller  
12 General of the United States shall submit to Congress a  
13 report on the adequacy of medicare payment rates to  
14 skilled nursing facilities and the extent to which medicare  
15 contributes to the financial viability of such facilities. Such  
16 report shall take into account the role of private payors,  
17 medicaid, and case mix on the financial performance of  
18 these facilities, and shall include an analysis (by specific  
19 RUG classification) of the number and characteristics of  
20 such facilities.

21       (e) HCFA STUDY OF CLASSIFICATION SYSTEMS FOR  
22 SNF RESIDENTS.—

23               (1) STUDY.—The Secretary of Health and  
24 Human Services shall conduct a study of the dif-  
25 ferent systems for categorizing patients in medicare

1 skilled nursing facilities in a manner that accounts  
2 for the relative resource utilization of different pa-  
3 tient types.

4 (2) REPORT.—Not later than January 1, 2005,  
5 the Secretary shall submit to Congress a report on  
6 the study conducted under subsection (a). Such re-  
7 port shall include such recommendations regarding  
8 changes in law as may be appropriate.

9 **SEC. 312. INCREASE IN NURSING COMPONENT OF PPS FED-**  
10 **ERAL RATE.**

11 (a) IN GENERAL.—The Secretary of Health and  
12 Human Services shall increase by 16.66 percent the nurs-  
13 ing component of the case-mix adjusted Federal prospec-  
14 tive payment rate specified in Tables 3 and 4 of the final  
15 rule published in the Federal Register by the Health Care  
16 Financing Administration on July 31, 2000 (65 Fed. Reg.  
17 46770) and as subsequently updated, effective for services  
18 furnished on or after April 1, 2001, and before October  
19 1, 2002.

20 (b) GAO AUDIT OF NURSING STAFF RATIOS.—

21 (1) AUDIT.—The Comptroller General of the  
22 United States shall conduct an audit of nursing  
23 staffing ratios in a representative sample of medi-  
24 care skilled nursing facilities. Such sample shall  
25 cover selected States and shall include broad rep-

1       resentation with respect to size, ownership, location,  
 2       and medicare volume. Such audit shall include an  
 3       examination of payroll records and medicaid cost re-  
 4       ports of individual facilities.

5           (2) REPORT.—Not later than August 1, 2002,  
 6       the Comptroller General shall submit to Congress a  
 7       report on the audits conducted under paragraph (1).  
 8       Such report shall include an assessment of the im-  
 9       pact of the increased payments under this subtitle  
 10      on increased nursing staff ratios and shall make rec-  
 11      ommendations as to whether increased payments  
 12      under subsection (a) should be continued.

13 **SEC. 313. APPLICATION OF SNF CONSOLIDATED BILLING**  
 14                   **REQUIREMENT LIMITED TO PART A COV-**  
 15                   **ERED STAYS.**

16      (a) IN GENERAL.—Section 1862(a)(18) (42 U.S.C.  
 17 1395y(a)(18)) is amended by striking “or of a part of a  
 18 facility that includes a skilled nursing facility (as deter-  
 19 mined under regulations),” and inserting “during a period  
 20 in which the resident is provided covered post-hospital ex-  
 21 tended care services (or, for services described in section  
 22 1861(s)(2)(D), which are furnished to such an individual  
 23 without regard to such period),”.

24      (b) CONFORMING AMENDMENTS.—(1) Section  
 25 1842(b)(6)(E) (42 U.S.C. 1395u(b)(6)(E)) is amended—

1 (A) by inserting “by, or under arrangements  
2 made by, a skilled nursing facility” after “fur-  
3 nished”;

4 (B) by striking “or of a part of a facility that  
5 includes a skilled nursing facility (as determined  
6 under regulations)”;

7 (C) by striking “(without regard to whether or  
8 not the item or service was furnished by the facility,  
9 by others under arrangement with them made by the  
10 facility, under any other contracting or consulting  
11 arrangement, or otherwise)”.

12 (2) Section 1842(t) (42 U.S.C. 1395u(t)) is amended  
13 by striking “by a physician” and “or of a part of a facility  
14 that includes a skilled nursing facility (as determined  
15 under regulations),”.

16 (3) Section 1866(a)(1)(H)(ii)(I) (42 U.S.C.  
17 1395cc(a)(1)(H)(ii)(I)) is amended by inserting after  
18 “who is a resident of the skilled nursing facility” the fol-  
19 lowing: “during a period in which the resident is provided  
20 covered post-hospital extended care services (or, for serv-  
21 ices described in section 1861(s)(2)(D), that are furnished  
22 to such an individual without regard to such period)”.

23 (c) EFFECTIVE DATE.—The amendments made by  
24 subsections (a) and (b) shall apply to services furnished  
25 on or after January 1, 2001.

1 (d) OVERSIGHT.—The Secretary of Health and  
 2 Human Services, through the Office of the Inspector Gen-  
 3 eral in the Department of Health and Human Services  
 4 or otherwise, shall monitor payments made under part B  
 5 of the title XVIII of the Social Security Act for items and  
 6 services furnished to residents of skilled nursing facilities  
 7 during a time in which the residents are not being pro-  
 8 vided medicare covered post-hospital extended care serv-  
 9 ices to ensure that there is not duplicate billing for serv-  
 10 ices or excessive services provided.

11 **SEC. 314. ADJUSTMENT OF REHABILITATION RUGS TO COR-**  
 12 **RECT ANOMALY IN PAYMENT RATES.**

13 (a) ADJUSTMENT FOR REHABILITATION RUGS.—

14 (1) IN GENERAL.—For purposes of computing  
 15 payments for covered skilled nursing facility services  
 16 under paragraph (1) of section 1888(e) of the Social  
 17 Security Act (42 U.S.C. 1395yy(e)) for such services  
 18 furnished on or after April 1, 2001, and before the  
 19 date described in section 101(c)(2) of BBRA (113  
 20 Stat. 1501A–324), the Secretary of Health and  
 21 Human Services shall increase by 6.7 percent the  
 22 adjusted Federal per diem rate otherwise determined  
 23 under paragraph (4) of such section (but for this  
 24 section) for covered skilled nursing facility services  
 25 for RUG–III rehabilitation groups described in para-

graph (2) furnished to an individual during the period in which such individual is classified in such a RUG–III category.

(2) REHABILITATION GROUPS DESCRIBED.—

The RUG–III rehabilitation groups for which the adjustment described in paragraph (1) applies are RUC, RUB, RUA, RVC, RVB, RVA, RHC, RHB, RHA, RMC, RMB, RMA, RLB, and RLA, as specified in Tables 3 and 4 of the final rule published in the Federal Register by the Health Care Financing Administration on July 31, 2000 (65 Fed. Reg. 46770).

(b) CORRECTION WITH RESPECT TO REHABILITATION RUGS.—

(1) IN GENERAL.—Section 101(b) of BBRA (113 Stat. 1501A–324) is amended by striking “CA1, RHC, RMC, and RMB” and inserting “and CA1”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after April 1, 2001.

(c) REVIEW BY OFFICE OF INSPECTOR GENERAL.—

The Inspector General of the Department of Health and Human Services shall review the medicare payment structure for services classified within rehabilitation resource

1 utilization groups (RUGs) (as in effect after the date of  
2 the enactment of the BBRA) to assess whether payment  
3 incentives exist for the delivery of inadequate care. Not  
4 later than October 1, 2001, the Inspector General shall  
5 submit to Congress a report on such review.

6 **SEC. 315. ESTABLISHMENT OF PROCESS FOR GEOGRAPHIC**  
7 **RECLASSIFICATION.**

8 (a) IN GENERAL.—The Secretary of Health and  
9 Human Services may establish a procedure for the geo-  
10 graphic reclassification of a skilled nursing facility for pur-  
11 poses of payment for covered skilled nursing facility serv-  
12 ices under the prospective payment system established  
13 under section 1888(e) of the Social Security Act (42  
14 U.S.C. 1395yy(e)). Such procedure may be based upon the  
15 method for geographic reclassifications for inpatient hos-  
16 pitals established under section 1886(d)(10) of the Social  
17 Security Act (42 U.S.C. 1395ww(d)(10)).

18 (b) REQUIREMENT FOR SKILLED NURSING FACILITY  
19 WAGE DATA.—In no case may the Secretary implement  
20 the procedure under subsection (a) before such time as  
21 the Secretary has collected data necessary to establish an  
22 area wage index for skilled nursing facilities based on  
23 wage data from such facilities.

## **Subtitle C—Hospice Care**

### **2 SEC. 321. FIVE PERCENT INCREASE IN PAYMENT BASE.**

3 (a) IN GENERAL.—Section 1814(i)(1)(C)(ii)(VI) (42  
4 U.S.C. 1395f(i)(1)(C)(ii)(VI)) is amended by inserting “,  
5 plus, in the case of fiscal year 2001, 5.0 percentage  
6 points” before the semicolon at the end.

7 (b) EFFECTIVE DATE.—The amendment made by  
8 subsection (a) shall apply to hospice care furnished on or  
9 after April 1, 2001. In applying clause (ii) of section  
10 1814(i)(1)(C) of the Social Security Act (42 U.S.C.  
11 1395f(i)(1)(C)) beginning with fiscal year 2002, the pay-  
12 ment rates in effect under such section during the period  
13 beginning on April 1, 2001, and ending on September 30,  
14 shall be treated as the payment rates in effect during fis-  
15 cal year 2001.

16 (c) NO EFFECT ON BBRA TEMPORARY INCREASE.—  
17 The provisions of this section shall have no effect on the  
18 application of section 131 of BBRA.

19 (d) APPLICATION OF WAGE INDEX.—Notwith-  
20 standing section 1814(i) of the Social Security Act (42  
21 U.S.C. 1395f(i)), the Secretary of Health and Human  
22 Services shall use 1.0043 as the hospice wage index value  
23 for the Wichita, Kansas Metropolitan Statistical Area in  
24 calculating payments under such section for a hospice pro-  
25 gram providing hospice care in such area during fiscal



1 year 2000. The Secretary may provide for an appropriate  
 2 timely lump sum payment to reflect the application of the  
 3 previous sentence.

4 (e) TECHNICAL AMENDMENT.—Section  
 5 1814(a)(7)(A)(ii) (42 U.S.C. 1395f(a)(7)(A)(ii)) is  
 6 amended by striking the period at the end and inserting  
 7 a semicolon.

8 **SEC. 322. CLARIFICATION OF PHYSICIAN CERTIFICATION.**

9 (a) CERTIFICATION BASED ON NORMAL COURSE OF  
 10 ILLNESS.—

11 (1) IN GENERAL.—Section 1814(a) (42 U.S.C.  
 12 1395f(a)) is amended by adding at the end the fol-  
 13 lowing new sentence: “The certification regarding  
 14 terminal illness of an individual under paragraph (7)  
 15 shall be based on the physician’s or medical direc-  
 16 tor’s clinical judgment regarding the normal course  
 17 of the individual’s illness.”.

18 (2) EFFECTIVE DATE.—The amendment made  
 19 by paragraph (1) shall apply to certifications made  
 20 on or after the date of the enactment of this Act.

21 (b) STUDY AND REPORT ON PHYSICIAN CERTIFI-  
 22 CATION REQUIREMENT FOR HOSPICE BENEFITS.—

23 (1) STUDY.—The Secretary of Health and  
 24 Human Services shall conduct a study to examine  
 25 the appropriateness of the certification regarding

1 terminal illness of an individual under section  
2 1814(a)(7) of the Social Security Act (42 U.S.C.  
3 1395f(a)(7)) that is required in order for such indi-  
4 vidual to receive hospice benefits under the medicare  
5 program under title XVIII of such Act. In con-  
6 ducting such study, the Secretary shall take into ac-  
7 count the effect of the amendment made by sub-  
8 section (a).

9 (2) REPORT.—Not later than 2 years after the  
10 date of the enactment of this Act, the Secretary of  
11 Health and Human Services shall submit to Con-  
12 gress a report on the study conducted under para-  
13 graph (1), together with any recommendations for  
14 legislation that the Secretary deems appropriate.

15 **SEC. 323. MEDPAC REPORT ON ACCESS TO, AND USE OF,**  
16 **HOSPICE BENEFIT.**

17 (a) IN GENERAL.—The Medicare Payment Advisory  
18 Commission shall conduct a study to examine the factors  
19 affecting the use of hospice benefits under the medicare  
20 program under title XVIII of the Social Security Act, in-  
21 cluding a delay in the time (relative to death) of entry  
22 into a hospice program, and differences in such use be-  
23 tween urban and rural hospice programs and based upon  
24 the presenting condition of the patient.

1 (b) REPORT.—Not later than 18 months after the  
 2 date of the enactment of this Act, the Commission shall  
 3 submit to Congress a report on the study conducted under  
 4 subsection (a), together with any recommendations for leg-  
 5 islation that the Commission deems appropriate.

## 6 **Subtitle D—Other Provisions**

### 7 **SEC. 331. RELIEF FROM MEDICARE PART A LATE ENROLL-** 8 **MENT PENALTY FOR GROUP BUY-IN FOR** 9 **STATE AND LOCAL RETIREES.**

10 (a) IN GENERAL.—Section 1818 (42 U.S.C. 1395i–  
 11 2) is amended—

12 (1) in subsection (c)(6), by inserting before the  
 13 semicolon at the end the following: “and shall be  
 14 subject to reduction in accordance with subsection  
 15 (d)(6)”;

16 (2) by adding at the end of subsection (d) the  
 17 following new paragraph:

18 “(6)(A) In the case where a State, a political subdivi-  
 19 sion of a State, or an agency or instrumentality of a State  
 20 or political subdivision thereof determines to pay, for the  
 21 life of each individual, the monthly premiums due under  
 22 paragraph (1) on behalf of each of the individuals in a  
 23 qualified State or local government retiree group who  
 24 meets the conditions of subsection (a), the amount of any  
 25 increase otherwise applicable under section 1839(b) (as

1 applied and modified by subsection (c)(6) of this section)  
2 with respect to the monthly premium for benefits under  
3 this part for an individual who is a member of such group  
4 shall be reduced by the total amount of taxes paid under  
5 section 3101(b) of the Internal Revenue Code of 1986 by  
6 such individual and under section 3111(b) by the employ-  
7 ers of such individual on behalf of such individual with  
8 respect to employment (as defined in section 3121(b) of  
9 such Code).

10 “(B) For purposes of this paragraph, the term ‘quali-  
11 fied State or local government retiree group’ means all of  
12 the individuals who retire prior to a specified date that  
13 is before January 1, 2002, from employment in one or  
14 more occupations or other broad classes of employees of—

15 “(i) the State;

16 “(ii) a political subdivision of the State; or

17 “(iii) an agency or instrumentality of the State  
18 or political subdivision of the State.”.

19 (b) EFFECTIVE DATE.—The amendments made by  
20 subsection (a) shall apply to premiums for months begin-  
21 ning with January 1, 2002.

**TITLE IV—PROVISIONS**  
**RELATING TO PART B**  
**Subtitle A—Hospital Outpatient**  
**Services**

**SEC. 401. REVISION OF HOSPITAL OUTPATIENT PPS PAY-**  
**MENT UPDATE.**

(a) IN GENERAL.—Section 1833(t)(3)(C)(iii) (42 U.S.C. 1395l(t)(3)(C)(iii)) is amended by striking “in each of 2000, 2001, and 2002” and inserting “in each of 2000 and 2002”.

(b) ADJUSTMENT FOR CASE MIX CHANGES.—

(1) IN GENERAL.—Section 1833(t)(3)(C) (42 U.S.C. 1395l(t)(3)(C)) is amended—

(A) by redesignating clause (iii) as clause (iv); and

(B) by inserting after clause (ii) the following new clause:

“(iii) ADJUSTMENT FOR SERVICE MIX CHANGES.—Insofar as the Secretary determines that the adjustments for service mix under paragraph (2) for a previous year (or estimates that such adjustments for a future year) did (or are likely to) result in a change in aggregate payments under this subsection during the year that are a re-

1           sult of changes in the coding or classifica-  
2           tion of covered OPD services that do not  
3           reflect real changes in service mix, the Sec-  
4           retary may adjust the conversion factor  
5           computed under this subparagraph for  
6           subsequent years so as to eliminate the ef-  
7           fect of such coding or classification  
8           changes.”.

9           (2) EFFECTIVE DATE.—The amendments made  
10          by paragraph (1) shall take effect as if included in  
11          the enactment of BBA.

12          (c) SPECIAL RULE FOR PAYMENT FOR 2001.—Not-  
13          withstanding the amendment made by subsection (a), for  
14          purposes of making payments under section 1833(t) of the  
15          Social Security Act (42 U.S.C. 1395l(t)) for covered OPD  
16          services furnished during 2001, the medicare OPD fee  
17          schedule amount under such section—

18               (1) for services furnished on or after January  
19               1, 2001, and before April 1, 2001, shall be the medi-  
20               care OPD fee schedule amount for 2001 as deter-  
21               mined under the provisions of law in effect on the  
22               day before the date of the enactment of this Act;  
23               and

24               (2) for services furnished on or after April 1,  
25               2001, and before January 1, 2002, shall be the fee

1 schedule amount (as determined taking into account  
 2 the amendment made by subsection (a)), increased  
 3 by a transitional percentage allowance equal to 0.32  
 4 percent (to account for the timing of implementation  
 5 of the full market basket update).

6 **SEC. 402. CLARIFYING PROCESS AND STANDARDS FOR DE-**  
 7 **TERMINING ELIGIBILITY OF DEVICES FOR**  
 8 **PASS-THROUGH PAYMENTS UNDER HOSPITAL**  
 9 **OUTPATIENT PPS.**

10 (a) IN GENERAL.—Section 1833(t)(6) (42 U.S.C.  
 11 1395l(t)(6)) is amended—

12 (1) by redesignating subparagraphs (C) and  
 13 (D) as subparagraphs (D) and (E), respectively; and

14 (2) by striking subparagraph (B) and inserting  
 15 the following new subparagraphs:

16 “(B) USE OF CATEGORIES IN DETER-  
 17 MINING ELIGIBILITY OF A DEVICE FOR PASS-  
 18 THROUGH PAYMENTS.—The following provi-  
 19 sions apply for purposes of determining whether  
 20 a medical device qualifies for additional pay-  
 21 ments under clause (ii) or (iv) of subparagraph  
 22 (A):

23 “(i) ESTABLISHMENT OF INITIAL CAT-  
 24 EGORIES.—

1                   “(I) IN GENERAL.—The Sec-  
2                   retary shall initially establish under  
3                   this clause categories of medical de-  
4                   vices based on type of device by April  
5                   1, 2001. Such categories shall be es-  
6                   tablished in a manner such that each  
7                   medical device that meets the require-  
8                   ments of clause (ii) or (iv) of subpara-  
9                   graph (A) as of January 1, 2001, is  
10                  included in such a category and no  
11                  such device is included in more than  
12                  one category. For purposes of the pre-  
13                  ceding sentence, whether a medical  
14                  device meets such requirements as of  
15                  such date shall be determined on the  
16                  basis of the program memoranda  
17                  issued before such date.

18                  “(II) AUTHORIZATION OF IMPLE-  
19                  MENTATION OTHER THAN THROUGH  
20                  REGULATIONS.—The categories may  
21                  be established under this clause by  
22                  program memorandum or otherwise,  
23                  after consultation with groups rep-  
24                  resenting hospitals, manufacturers of



1 medical devices, and other affected  
2 parties.

3 “(ii) ESTABLISHING CRITERIA FOR  
4 ADDITIONAL CATEGORIES.—

5 “(I) IN GENERAL.—The Sec-  
6 retary shall establish criteria that will  
7 be used for creation of additional cat-  
8 egories (other than those established  
9 under clause (i)) through rulemaking  
10 (which may include use of an interim  
11 final rule with comment period).

12 “(II) STANDARD.—Such cat-  
13 egories shall be established under this  
14 clause in a manner such that no med-  
15 ical device is described by more than  
16 one category. Such criteria shall in-  
17 clude a test of whether the average  
18 cost of devices that would be included  
19 in a category and are in use at the  
20 time the category is established is not  
21 insignificant, as described in subpara-  
22 graph (A)(iv)(II).

23 “(III) DEADLINE.—Criteria shall  
24 first be established under this clause  
25 by July 1, 2001. The Secretary may

1 establish in compelling circumstances  
2 categories under this clause before the  
3 date such criteria are established.

4 “(IV) ADDING CATEGORIES.—

5 The Secretary shall promptly establish  
6 a new category of medical devices  
7 under this clause for any medical de-  
8 vice that meets the requirements of  
9 subparagraph (A)(iv) and for which  
10 none of the categories in effect (or  
11 that were previously in effect) is ap-  
12 propriate.

13 “(iii) PERIOD FOR WHICH CATEGORY  
14 IS IN EFFECT.—A category of medical de-  
15 vices established under clause (i) or (ii)  
16 shall be in effect for a period of at least 2  
17 years, but not more than 3 years, that  
18 begins—

19 “(I) in the case of a category es-  
20 tablished under clause (i), on the first  
21 date on which payment was made  
22 under this paragraph for any device  
23 described by such category (including  
24 payments made during the period be-  
25 fore April 1, 2001); and

1 “(II) in the case of any other  
2 category, on the first date on which  
3 payment is made under this para-  
4 graph for any medical device that is  
5 described by such category.

6 “(iv) REQUIREMENTS TREATED AS  
7 MET.—A medical device shall be treated as  
8 meeting the requirements of subparagraph  
9 (A)(iv), regardless of whether the device  
10 meets the requirement of subclause (I) of  
11 such subparagraph, if—

12 “(I) the device is described by a  
13 category established and in effect  
14 under clause (i); or

15 “(II) the device is described by a  
16 category established and in effect  
17 under clause (ii) and an application  
18 under section 515 of the Federal  
19 Food, Drug, and Cosmetic Act has  
20 been approved with respect to the de-  
21 vice, or the device has been cleared for  
22 market under section 510(k) of such  
23 Act, or the device is exempt from the  
24 requirements of section 510(k) of  
25 such Act pursuant to subsection (l) or

1 (m) of section 510 of such Act or sec-  
2 tion 520(g) of such Act.

3 Nothing in this clause shall be construed  
4 as requiring an application or prior ap-  
5 proval (other than that described in sub-  
6 clause (II)) in order for a covered device  
7 described by a category to qualify for pay-  
8 ment under this paragraph.

9 “(C) LIMITED PERIOD OF PAYMENT.—

10 “(i) DRUGS AND BIOLOGICALS.—The  
11 payment under this paragraph with respect  
12 to a drug or biological shall only apply dur-  
13 ing a period of at least 2 years, but not  
14 more than 3 years, that begins—

15 “(I) on the first date this sub-  
16 section is implemented in the case of  
17 a drug or biological described in  
18 clause (i), (ii), or (iii) of subparagraph  
19 (A) and in the case of a drug or bio-  
20 logical described in subparagraph  
21 (A)(iv) and for which payment under  
22 this part is made as an outpatient  
23 hospital service before such first date;  
24 or

1 “(II) in the case of a drug or bio-  
 2 logical described in subparagraph  
 3 (A)(iv) not described in subclause (I),  
 4 on the first date on which payment is  
 5 made under this part for the drug or  
 6 biological as an outpatient hospital  
 7 service.

8 “(ii) MEDICAL DEVICES.—Payment  
 9 shall be made under this paragraph with  
 10 respect to a medical device only if such  
 11 device—

12 “(I) is described by a category of  
 13 medical devices established and in ef-  
 14 fect under subparagraph (B); and

15 “(II) is provided as part of a  
 16 service (or group of services) paid for  
 17 under this subsection and provided  
 18 during the period for which such cat-  
 19 egory is in effect under such subpara-  
 20 graph.”.

21 (b) CONFORMING AMENDMENTS.—Section 1833(t)  
 22 (42 U.S.C. 1395l(t)) is further amended—

23 (1) in paragraph (6)(A)(iv)(II), by striking “the  
 24 cost of the device, drug, or biological” and inserting

1 “the cost of the drug or biological or the average  
2 cost of the category of devices”;

3 (2) in paragraph (6)(D) (as redesignated by  
4 subsection (a)(1)), by striking “subparagraph  
5 (D)(iii)” in the matter preceding clause (i) and in-  
6 serting “subparagraph (E)(iii)”; and

7 (3) in paragraph (12)(E), by striking “addi-  
8 tional payments (consistent with paragraph (6)(B))”  
9 and inserting “additional payments, the determina-  
10 tion and deletion of initial and new categories (con-  
11 sistent with subparagraphs (B) and (C) of para-  
12 graph (6))”.

13 (c) EFFECTIVE DATE.—The amendments made by  
14 this section take effect on the date of the enactment of  
15 this Act.

16 (d) TRANSITION.—

17 (1) IN GENERAL.—In the case of a medical de-  
18 vice provided as part of a service (or group of serv-  
19 ices) furnished during the period before initial cat-  
20 egories are implemented under subparagraph (B)(i)  
21 of section 1833(t)(6) of the Social Security Act (as  
22 amended by subsection (a)), payment shall be made  
23 for such device under such section in accordance  
24 with the provisions in effect before the date of the  
25 enactment of this Act. In addition, beginning on the

1 date that is 30 days after the date of the enactment  
2 of this Act, payment shall be made for such a device  
3 that is not included in a program memorandum de-  
4 scribed in such subparagraph if the Secretary of  
5 Health and Human Services determines that the de-  
6 vice (including a device that would have been in-  
7 cluded in such program memoranda but for the re-  
8 quirement of subparagraph (A)(iv)(I) of that sec-  
9 tion) is likely to be described by such an initial cat-  
10 egory.

11 (2) APPLICATION OF CURRENT PROCESS.—Not-  
12 withstanding any other provision of law, the Sec-  
13 retary shall continue to accept applications with re-  
14 spect to medical devices under the process estab-  
15 lished pursuant to paragraph (6) of section 1833(t)  
16 of the Social Security Act (as in effect on the day  
17 before the date of the enactment of this Act)  
18 through December 1, 2000, and any device—

19 (A) with respect to which an application  
20 was submitted (pursuant to such process) on or  
21 before such date; and

22 (B) that meets the requirements of clause  
23 (ii) or (iv) of subparagraph (A) of such para-  
24 graph (as determined pursuant to such proc-  
25 ess),

1 shall be treated as a device with respect to which an  
 2 initial category is required to be established under  
 3 subparagraph (B)(i) of such paragraph (as amended  
 4 by subsection (a)(2)).

5 **SEC. 403. APPLICATION OF OPD PPS TRANSITIONAL COR-**  
 6 **RIDOR PAYMENTS TO CERTAIN HOSPITALS**  
 7 **THAT DID NOT SUBMIT A 1996 COST REPORT.**

8 (a) IN GENERAL.—Section 1833(t)(7)(F)(ii)(I) (42  
 9 U.S.C. 1395l(t)(7)(F)(ii)(I)) is amended by inserting “(or  
 10 in the case of a hospital that did not submit a cost report  
 11 for such period, during the first subsequent cost reporting  
 12 period ending before 2001 for which the hospital sub-  
 13 mitted a cost report)” after “1996”.

14 (b) EFFECTIVE DATE.—The amendment made by  
 15 subsection (a) shall take effect as if included in the enact-  
 16 ment of BBRA.

17 **SEC. 404. APPLICATION OF RULES FOR DETERMINING PRO-**  
 18 **VIDER-BASED STATUS FOR CERTAIN ENTI-**  
 19 **TIES.**

20 (a) GRANDFATHER.—Notwithstanding any other pro-  
 21 vision of law, effective October 1, 2000, for purposes of  
 22 provider-based status under title XVIII of the Social Secu-  
 23 rity Act—

24 (1) any facility or organization that is treated  
 25 as provider-based in relation to a hospital or critical



1 access hospital under such title as of such date shall  
2 continue to be treated as provider-based in relation  
3 to such hospital or critical access hospital under  
4 such title until October 1, 2002; and

5 (2) the requirements, limitations, and exclu-  
6 sions specified in subsections (d), (e), (f), and (h)  
7 of section 413.65 of title 42, Code of Federal Regu-  
8 lations, shall not apply to such facility or organiza-  
9 tion in relation to such hospital or critical access  
10 hospital until October 1, 2002.

11 (b) CONTINUING CRITERIA FOR MEETING GEO-  
12 GRAPHIC LOCATION REQUIREMENT.—Except as provided  
13 in subsection (a), in making determinations of provider-  
14 based status on or after October 1, 2000, the following  
15 rules shall apply:

16 (1) The facility or organization shall be treated  
17 as satisfying any requirements and standards for ge-  
18 ographic location in relation to a hospital or a crit-  
19 ical access hospital if the facility or organization—

20 (A) satisfies the requirements of section  
21 413.65(d)(7) of title 42, Code of Federal Regu-  
22 lations; or

23 (B) is located not more than 35 miles from  
24 the main campus of the hospital or critical ac-  
25 cess hospital.

1           (2) The facility or organization shall be treated  
2           as satisfying any of the requirements and standards  
3           for geographic location in relation to a hospital or a  
4           critical access hospital if the facility or organization  
5           is owned and operated by a hospital or critical ac-  
6           cess hospital that—

7                   (A) is owned or operated by a unit of State  
8                   or local government, is a public or private non-  
9                   profit corporation that is formally granted gov-  
10                  ernmental powers by a unit of State or local  
11                  government, or is a private hospital that has a  
12                  contract with a State or local government that  
13                  includes the operation of clinics located off the  
14                  main campus of the hospital to assure access in  
15                  a well-defined service area to health care serv-  
16                  ices for low-income individuals who are not enti-  
17                  tled to benefits under title XVIII (or medical  
18                  assistance under a State plan under title XIX)  
19                  of the Social Security Act; and

20                  (B) has a disproportionate share adjust-  
21                  ment percentage (as determined under section  
22                  1886(d)(5)(F) of such Act (42 U.S.C.  
23                  1395ww(d)(5)(F))) greater than 11.75 percent  
24                  or is described in clause (i)(II) of such section.

1       (c) TEMPORARY CRITERIA.—For purposes of title  
 2 XVIII of the Social Security Act, a facility or organization  
 3 for which a determination of provider-based status in rela-  
 4 tion to a hospital or critical access hospital is requested  
 5 on or after October 1, 2000, and before October 1, 2002,  
 6 shall be treated as having provider-based status in relation  
 7 to such a hospital or a critical access hospital for any pe-  
 8 riod before a determination is made with respect to such  
 9 status pursuant to such request.

10       (d) DEFINITIONS.—For purposes of this section, the  
 11 terms “hospital” and “critical access hospital” have the  
 12 meanings given such terms in subsections (e) and  
 13 (mm)(1), respectively, of section 1861 of the Social Secu-  
 14 rity Act (42 U.S.C. 1395x).

15 **SEC. 405. TREATMENT OF CHILDREN’S HOSPITALS UNDER**  
 16 **PROSPECTIVE PAYMENT SYSTEM.**

17       (a) IN GENERAL.—Section 1833(t) (42 U.S.C.  
 18 1395l(t)) is amended—

19               (1) in the heading of paragraph (7)(D)(ii), by  
 20 inserting “AND CHILDREN’S HOSPITALS” after “CAN-  
 21 CER HOSPITALS”; and

22               (2) in paragraphs (7)(D)(ii) and (11), by strik-  
 23 ing “section 1886(d)(1)(B)(v)” and inserting  
 24 “clause (iii) or (v) of section 1886(d)(1)(B)”.

1 (b) EFFECTIVE DATE.—The amendments made by  
 2 subsection (a) shall apply as if included in the enactment  
 3 of section 202 of BBRA (113 Stat. 1501A–342).

4 **SEC. 406. INCLUSION OF TEMPERATURE MONITORED**  
 5 **CRYOABLATION IN TRANSITIONAL PASS-**  
 6 **THROUGH FOR CERTAIN MEDICAL DEVICES,**  
 7 **DRUGS, AND BIOLOGICALS UNDER OPD PPS.**

8 (a) IN GENERAL.—Section 1833(t)(6)(A)(ii) (42  
 9 U.S.C. 1395l(t)(6)(A)(ii)) is amended by inserting “or  
 10 temperature monitored cryoablation” after “device of  
 11 brachytherapy”.

12 (b) EFFECTIVE DATE.—The amendment made by  
 13 subsection (a) shall apply to devices furnished on or after  
 14 April 1, 2001.

15 **Subtitle B—Provisions Relating to**  
 16 **Physicians’ Services**

17 **SEC. 411. GAO STUDIES RELATING TO PHYSICIANS’ SERV-**  
 18 **ICES.**

19 (a) STUDY OF SPECIALIST PHYSICIANS’ SERVICES  
 20 FURNISHED IN PHYSICIANS’ OFFICES AND HOSPITAL  
 21 OUTPATIENT DEPARTMENT SERVICES.—

22 (1) STUDY.—The Comptroller General of the  
 23 United States shall conduct a study to examine the  
 24 appropriateness of furnishing in physicians’ offices  
 25 specialist physicians’ services (such as gastro-

1 intestinal endoscopic physicians' services) which are  
2 ordinarily furnished in hospital outpatient depart-  
3 ments. In conducting this study, the Comptroller  
4 General shall—

5 (A) review available scientific and clinical  
6 evidence about the safety of performing proce-  
7 dures in physicians' offices and hospital out-  
8 patient departments;

9 (B) assess whether resource-based practice  
10 expense relative values established by the Sec-  
11 retary of Health and Human Services under the  
12 medicare physician fee schedule under section  
13 1848 of the Social Security Act (42 U.S.C.  
14 1395w-4) for such specialist physicians' serv-  
15 ices furnished in physicians' offices and hospital  
16 outpatient departments create an incentive to  
17 furnish such services in physicians' offices in-  
18 stead of hospital outpatient departments; and

19 (C) assess the implications for access to  
20 care for medicare beneficiaries if the medicare  
21 program were not to cover such services in phy-  
22 sicians' offices.

23 (2) REPORT.—Not later than July 1, 2001, the  
24 Comptroller General shall submit to Congress a re-  
25 port on such study and include such recommenda-

1 tions as the Comptroller General determines to be  
2 appropriate.

3 (b) STUDY OF THE RESOURCE-BASED PRACTICE EX-  
4 PENSE SYSTEM.—

5 (1) STUDY.—The Comptroller General of the  
6 United States shall conduct a study on the refine-  
7 ments to the practice expense relative value units  
8 during the transition to a resource-based practice ex-  
9 pense system for physician payments under the  
10 medicare program under title XVIII of the Social  
11 Security Act. Such study shall examine how the Sec-  
12 retary of Health and Human Services has accepted  
13 and used the practice expense data submitted under  
14 section 212 of BBRA (113 Stat. 1501A–350).

15 (2) REPORT.—Not later than July 1, 2001, the  
16 Comptroller General shall submit to Congress a re-  
17 port on the study conducted under paragraph (1) to-  
18 gether with recommendations regarding—

19 (A) improvements in the process for ac-  
20 ceptance and use of practice expense data  
21 under section 212 of BBRA;

22 (B) any change or adjustment that is ap-  
23 propriate to ensure full access to a spectrum of  
24 care for beneficiaries under the medicare pro-  
25 gram; and

1 (C) the appropriateness of payments to  
2 physicians.

3 **SEC. 412. PHYSICIAN GROUP PRACTICE DEMONSTRATION.**

4 (a) IN GENERAL.—Title XVIII is amended by insert-  
5 ing after section 1866 the following new sections:

6 “DEMONSTRATION OF APPLICATION OF PHYSICIAN  
7 VOLUME INCREASES TO GROUP PRACTICES

8 “SEC. 1866A. (a) DEMONSTRATION PROGRAM AU-  
9 THORIZED.—

10 “(1) IN GENERAL.—The Secretary shall con-  
11 duct demonstration projects to test and, if proven ef-  
12 fective, expand the use of incentives to health care  
13 groups participating in the program under this title  
14 that—

15 “(A) encourage coordination of the care  
16 furnished to individuals under the programs  
17 under parts A and B by institutional and other  
18 providers, practitioners, and suppliers of health  
19 care items and services;

20 “(B) encourage investment in administra-  
21 tive structures and processes to ensure efficient  
22 service delivery; and

23 “(C) reward physicians for improving  
24 health outcomes.

25 Such projects shall focus on the efficiencies of fur-  
26 nishing health care in a group-practice setting as

1 compared to the efficiencies of furnishing health care  
2 in other health care delivery systems.

3 “(2) ADMINISTRATION BY CONTRACT.—Except  
4 as otherwise specifically provided, the Secretary may  
5 administer the program under this section in accord-  
6 ance with section 1866B.

7 “(3) DEFINITIONS.—For purposes of this sec-  
8 tion, terms have the following meanings:

9 “(A) PHYSICIAN.—Except as the Secretary  
10 may otherwise provide, the term ‘physician’  
11 means any individual who furnishes services  
12 which may be paid for as physicians’ services  
13 under this title.

14 “(B) HEALTH CARE GROUP.—The term  
15 ‘health care group’ means a group of physicians  
16 (as defined in subparagraph (A)) organized at  
17 least in part for the purpose of providing physi-  
18 cians’ services under this title. As the Secretary  
19 finds appropriate, a health care group may in-  
20 clude a hospital and any other individual or en-  
21 tity furnishing items or services for which pay-  
22 ment may be made under this title that is affili-  
23 ated with the health care group under an ar-  
24 rangement structured so that such individual or  
25 entity participates in a demonstration under



1           this section and will share in any bonus earned  
2           under subsection (d).

3           “(b) ELIGIBILITY CRITERIA.—

4           “(1) IN GENERAL.—The Secretary is authorized  
5           to establish criteria for health care groups eligible to  
6           participate in a demonstration under this section, in-  
7           cluding criteria relating to numbers of health care  
8           professionals in, and of patients served by, the  
9           group, scope of services provided, and quality of  
10          care.

11          “(2) PAYMENT METHOD.—A health care group  
12          participating in the demonstration under this section  
13          shall agree with respect to services furnished to  
14          beneficiaries within the scope of the demonstration  
15          (as determined under subsection (c))—

16                  “(A) to be paid on a fee-for-service basis;  
17                  and

18                  “(B) that payment with respect to all such  
19                  services furnished by members of the health  
20                  care group to such beneficiaries shall (where de-  
21                  termined appropriate by the Secretary) be made  
22                  to a single entity.

23          “(3) DATA REPORTING.—A health care group  
24          participating in a demonstration under this section  
25          shall report to the Secretary such data, at such

1 times and in such format as the Secretary requires,  
2 for purposes of monitoring and evaluation of the  
3 demonstration under this section.

4 “(c) PATIENTS WITHIN SCOPE OF DEMONSTRA-  
5 TION.—

6 “(1) IN GENERAL.—The Secretary shall specify,  
7 in accordance with this subsection, the criteria for  
8 identifying those patients of a health care group who  
9 shall be considered within the scope of the dem-  
10 onstration under this section for purposes of applica-  
11 tion of subsection (d) and for assessment of the ef-  
12 fectiveness of the group in achieving the objectives  
13 of this section.

14 “(2) OTHER CRITERIA.—The Secretary may es-  
15 tablish additional criteria for inclusion of bene-  
16 ficiaries within a demonstration under this section,  
17 which may include frequency of contact with physi-  
18 cians in the group or other factors or criteria that  
19 the Secretary finds to be appropriate.

20 “(3) NOTICE REQUIREMENTS.—In the case of  
21 each beneficiary determined to be within the scope  
22 of a demonstration under this section with respect to  
23 a specific health care group, the Secretary shall en-  
24 sure that such beneficiary is notified of the incen-  
25 tives, and of any waivers of coverage or payment

1 rules, applicable to such group under such dem-  
2 onstration.

3 “(d) INCENTIVES.—

4 “(1) PERFORMANCE TARGET.—The Secretary  
5 shall establish for each health care group partici-  
6 pating in a demonstration under this section—

7 “(A) a base expenditure amount, equal to  
8 the average total payments under parts A and  
9 B for patients served by the health care group  
10 on a fee-for-service basis in a base period deter-  
11 mined by the Secretary; and

12 “(B) an annual per capita expenditure tar-  
13 get for patients determined to be within the  
14 scope of the demonstration, reflecting the base  
15 expenditure amount adjusted for risk and ex-  
16 pected growth rates.

17 “(2) INCENTIVE BONUS.—The Secretary shall  
18 pay to each participating health care group (subject  
19 to paragraph (4)) a bonus for each year under the  
20 demonstration equal to a portion of the medicare  
21 savings realized for such year relative to the per-  
22 formance target.

23 “(3) ADDITIONAL BONUS FOR PROCESS AND  
24 OUTCOME IMPROVEMENTS.—At such time as the  
25 Secretary has established appropriate criteria based

1 on evidence the Secretary determines to be suffi-  
2 cient, the Secretary shall also pay to a participating  
3 health care group (subject to paragraph (4)) an ad-  
4 ditional bonus for a year, equal to such portion as  
5 the Secretary may designate of the saving to the  
6 program under this title resulting from process im-  
7 provements made by and patient outcome improve-  
8 ments attributable to activities of the group.

9 “(4) LIMITATION.—The Secretary shall limit  
10 bonus payments under this section as necessary to  
11 ensure that the aggregate expenditures under this  
12 title (inclusive of bonus payments) with respect to  
13 patients within the scope of the demonstration do  
14 not exceed the amount which the Secretary esti-  
15 mates would be expended if the demonstration  
16 projects under this section were not implemented.

17 “PROVISIONS FOR ADMINISTRATION OF DEMONSTRATION  
18 PROGRAM

19 “SEC. 1866B. (a) GENERAL ADMINISTRATIVE AU-  
20 THORITY.—

21 “(1) BENEFICIARY ELIGIBILITY.—Except as  
22 otherwise provided by the Secretary, an individual  
23 shall only be eligible to receive benefits under the  
24 program under section 1866A (in this section re-  
25 ferred to as the ‘demonstration program’) if such  
26 individual—

1           “(A) is enrolled under the program under  
2           part B and entitled to benefits under part A;  
3           and

4           “(B) is not enrolled in a Medicare+Choice  
5           plan under part C, an eligible organization  
6           under a contract under section 1876 (or a simi-  
7           lar organization operating under a demonstra-  
8           tion project authority), an organization with an  
9           agreement under section 1833(a)(1)(A), or a  
10          PACE program under section 1894.

11          “(2) SECRETARY’S DISCRETION AS TO SCOPE  
12          OF PROGRAM.—The Secretary may limit the imple-  
13          mentation of the demonstration program to—

14               “(A) a geographic area (or areas) that the  
15               Secretary designates for purposes of the pro-  
16               gram, based upon such criteria as the Secretary  
17               finds appropriate;

18               “(B) a subgroup (or subgroups) of bene-  
19               ficiaries or individuals and entities furnishing  
20               items or services (otherwise eligible to partici-  
21               pate in the program), selected on the basis of  
22               the number of such participants that the Sec-  
23               retary finds consistent with the effective and ef-  
24               ficient implementation of the program;

1           “(C) an element (or elements) of the pro-  
2           gram that the Secretary determines to be suit-  
3           able for implementation; or

4           “(D) any combination of any of the limits  
5           described in subparagraphs (A) through (C).

6           “(3) VOLUNTARY RECEIPT OF ITEMS AND  
7           SERVICES.—Items and services shall be furnished to  
8           an individual under the demonstration program only  
9           at the individual’s election.

10          “(4) AGREEMENTS.—The Secretary is author-  
11          ized to enter into agreements with individuals and  
12          entities to furnish health care items and services to  
13          beneficiaries under the demonstration program.

14          “(5) PROGRAM STANDARDS AND CRITERIA.—  
15          The Secretary shall establish performance standards  
16          for the demonstration program including, as applica-  
17          ble, standards for quality of health care items and  
18          services, cost-effectiveness, beneficiary satisfaction,  
19          and such other factors as the Secretary finds appro-  
20          priate. The eligibility of individuals or entities for  
21          the initial award, continuation, and renewal of  
22          agreements to provide health care items and services  
23          under the program shall be conditioned, at a min-  
24          imum, on performance that meets or exceeds such  
25          standards.

1           “(6) ADMINISTRATIVE REVIEW OF DECISIONS  
2       AFFECTING INDIVIDUALS AND ENTITIES FUR-  
3       NISHING SERVICES.—An individual or entity fur-  
4       nishing services under the demonstration program  
5       shall be entitled to a review by the program adminis-  
6       trator (or, if the Secretary has not contracted with  
7       a program administrator, by the Secretary) of a de-  
8       cision not to enter into, or to terminate, or not to  
9       renew, an agreement with the entity to provide  
10      health care items or services under the program.

11          “(7) SECRETARY’S REVIEW OF MARKETING MA-  
12      TERIALS.—An agreement with an individual or enti-  
13      ty furnishing services under the demonstration pro-  
14      gram shall require the individual or entity to guar-  
15      antee that it will not distribute materials that mar-  
16      ket items or services under the program without the  
17      Secretary’s prior review and approval.

18          “(8) PAYMENT IN FULL.—

19              “(A) IN GENERAL.—Except as provided in  
20      subparagraph (B), an individual or entity re-  
21      ceiving payment from the Secretary under a  
22      contract or agreement under the demonstration  
23      program shall agree to accept such payment as  
24      payment in full, and such payment shall be in  
25      lieu of any payments to which the individual or

1           entity would otherwise be entitled under this  
2           title.

3                   “(B) COLLECTION OF DEDUCTIBLES AND  
4           COINSURANCE.—Such individual or entity may  
5           collect any applicable deductible or coinsurance  
6           amount from a beneficiary.

7           “(b) CONTRACTS FOR PROGRAM ADMINISTRATION.—

8                   “(1) IN GENERAL.—The Secretary may admin-  
9           ister the demonstration program through a contract  
10          with a program administrator in accordance with the  
11          provisions of this subsection.

12                   “(2) SCOPE OF PROGRAM ADMINISTRATOR CON-  
13          TRACTS.—The Secretary may enter into such con-  
14          tracts for a limited geographic area, or on a regional  
15          or national basis.

16                   “(3) ELIGIBLE CONTRACTORS.—The Secretary  
17          may contract for the administration of the program  
18          with—

19                   “(A) an entity that, under a contract  
20          under section 1816 or 1842, determines the  
21          amount of and makes payments for health care  
22          items and services furnished under this title; or

23                   “(B) any other entity with substantial ex-  
24          perience in managing the type of program con-  
25          cerned.



1           “(4) CONTRACT AWARD, DURATION, AND RE-  
2       NEWAL.—

3           “(A) IN GENERAL.—A contract under this  
4       subsection shall be for an initial term of up to  
5       three years, renewable for additional terms of  
6       up to three years.

7           “(B) NONCOMPETITIVE AWARD AND RE-  
8       NEWAL FOR ENTITIES ADMINISTERING PART A  
9       OR PART B PAYMENTS.—The Secretary may  
10      enter or renew a contract under this subsection  
11      with an entity described in paragraph (3)(A)  
12      without regard to the requirements of section 5  
13      of title 41, United States Code.

14          “(5) APPLICABILITY OF FEDERAL ACQUISITION  
15      REGULATION.—The Federal Acquisition Regulation  
16      shall apply to program administration contracts  
17      under this subsection.

18          “(6) PERFORMANCE STANDARDS.—The Sec-  
19      retary shall establish performance standards for the  
20      program administrator including, as applicable,  
21      standards for the quality and cost-effectiveness of  
22      the program administered, and such other factors as  
23      the Secretary finds appropriate. The eligibility of en-  
24      tities for the initial award, continuation, and renewal  
25      of program administration contracts shall be condi-

tioned, at a minimum, on performance that meets or exceeds such standards.

“(7) FUNCTIONS OF PROGRAM ADMINISTRATOR.—A program administrator shall perform any or all of the following functions, as specified by the Secretary:

“(A) AGREEMENTS WITH ENTITIES FURNISHING HEALTH CARE ITEMS AND SERVICES.—Determine the qualifications of entities seeking to enter or renew agreements to provide services under the demonstration program, and as appropriate enter or renew (or refuse to enter or renew) such agreements on behalf of the Secretary.

“(B) ESTABLISHMENT OF PAYMENT RATES.—Negotiate or otherwise establish, subject to the Secretary’s approval, payment rates for covered health care items and services.

“(C) PAYMENT OF CLAIMS OR FEES.—Administer payments for health care items or services furnished under the program.

“(D) PAYMENT OF BONUSES.—Using such guidelines as the Secretary shall establish, and subject to the approval of the Secretary, make bonus payments as described in subsection

1 (c)(2)(A)(ii) to entities furnishing items or serv-  
2 ices for which payment may be made under the  
3 program.

4 “(E) OVERSIGHT.—Monitor the compli-  
5 ance of individuals and entities with agreements  
6 under the program with the conditions of par-  
7 ticipation.

8 “(F) ADMINISTRATIVE REVIEW.—Conduct  
9 reviews of adverse determinations specified in  
10 subsection (a)(6).

11 “(G) REVIEW OF MARKETING MATE-  
12 RIALS.—Conduct a review of marketing mate-  
13 rials proposed by an entity furnishing services  
14 under the program.

15 “(H) ADDITIONAL FUNCTIONS.—Perform  
16 such other functions as the Secretary may  
17 specify.

18 “(8) LIMITATION OF LIABILITY.—The provi-  
19 sions of section 1157(b) shall apply with respect to  
20 activities of contractors and their officers, employ-  
21 ees, and agents under a contract under this sub-  
22 section.

23 “(9) INFORMATION SHARING.—Notwithstanding  
24 section 1106 and section 552a of title 5, United  
25 States Code, the Secretary is authorized to disclose

1 to an entity with a program administration contract  
2 under this subsection such information (including  
3 medical information) on individuals receiving health  
4 care items and services under the program as the  
5 entity may require to carry out its responsibilities  
6 under the contract.

7 “(c) RULES APPLICABLE TO BOTH PROGRAM  
8 AGREEMENTS AND PROGRAM ADMINISTRATION CON-  
9 TRACTS.—

10 “(1) RECORDS, REPORTS, AND AUDITS.—The  
11 Secretary is authorized to require entities with  
12 agreements to provide health care items or services  
13 under the demonstration program, and entities with  
14 program administration contracts under subsection  
15 (b), to maintain adequate records, to afford the Sec-  
16 retary access to such records (including for audit  
17 purposes), and to furnish such reports and other  
18 materials (including audited financial statements  
19 and performance data) as the Secretary may require  
20 for purposes of implementation, oversight, and eval-  
21 uation of the program and of individuals’ and enti-  
22 ties’ effectiveness in performance of such agreements  
23 or contracts.

24 “(2) BONUSES.—Notwithstanding any other  
25 provision of law, but subject to subparagraph

1 (B)(ii), the Secretary may make bonus payments  
2 under the demonstration program from the Federal  
3 Health Insurance Trust Fund and the Federal Sup-  
4 plementary Medical Insurance Trust Fund in  
5 amounts that do not exceed the amounts authorized  
6 under the program in accordance with the following:

7 “(A) PAYMENTS TO PROGRAM ADMINIS-  
8 TRATORS.—The Secretary may make bonus  
9 payments under the program to program ad-  
10 ministrators.

11 “(B) PAYMENTS TO ENTITIES FURNISHING  
12 SERVICES.—

13 “(i) IN GENERAL.—Subject to clause  
14 (ii), the Secretary may make bonus pay-  
15 ments to individuals or entities furnishing  
16 items or services for which payment may  
17 be made under the demonstration pro-  
18 gram, or may authorize the program ad-  
19 ministrator to make such bonus payments  
20 in accordance with such guidelines as the  
21 Secretary shall establish and subject to the  
22 Secretary’s approval.

23 “(ii) LIMITATIONS.—The Secretary  
24 may condition such payments on the  
25 achievement of such standards related to

1 efficiency, improvement in processes or  
2 outcomes of care, or such other factors as  
3 the Secretary determines to be appropriate.

4 “(3) ANTIDISCRIMINATION LIMITATION.—The  
5 Secretary shall not enter into an agreement with an  
6 entity to provide health care items or services under  
7 the demonstration program, or with an entity to ad-  
8 minister the program, unless such entity guarantees  
9 that it will not deny, limit, or condition the coverage  
10 or provision of benefits under the program, for indi-  
11 viduals eligible to be enrolled under such program,  
12 based on any health status-related factor described  
13 in section 2702(a)(1) of the Public Health Service  
14 Act.

15 “(d) LIMITATIONS ON JUDICIAL REVIEW.—The fol-  
16 lowing actions and determinations with respect to the  
17 demonstration program shall not be subject to review by  
18 a judicial or administrative tribunal:

19 “(1) Limiting the implementation of the pro-  
20 gram under subsection (a)(2).

21 “(2) Establishment of program participation  
22 standards under subsection (a)(5) or the denial or  
23 termination of, or refusal to renew, an agreement  
24 with an entity to provide health care items and serv-  
25 ices under the program.

1           “(3) Establishment of program administration  
2           contract performance standards under subsection  
3           (b)(6), the refusal to renew a program administra-  
4           tion contract, or the noncompetitive award or re-  
5           newal of a program administration contract under  
6           subsection (b)(4)(B).

7           “(4) Establishment of payment rates, through  
8           negotiation or otherwise, under a program agree-  
9           ment or a program administration contract.

10           “(5) A determination with respect to the pro-  
11           gram (where specifically authorized by the program  
12           authority or by subsection (c)(2))—

13                   “(A) as to whether cost savings have been  
14                   achieved, and the amount of savings; or

15                   “(B) as to whether, to whom, and in what  
16                   amounts bonuses will be paid.

17           “(e) APPLICATION LIMITED TO PARTS A AND B.—  
18           None of the provisions of this section or of the demonstra-  
19           tion program shall apply to the programs under part C.

20           “(f) REPORTS TO CONGRESS.—Not later than two  
21           years after the date of the enactment of this section, and  
22           biennially thereafter for six years, the Secretary shall re-  
23           port to Congress on the use of authorities under the dem-  
24           onstration program. Each report shall address the impact

1 of the use of those authorities on expenditures, access, and  
 2 quality under the programs under this title.”.

3 (b) GAO REPORT.—Not later than 2 years after the  
 4 date on which the demonstration project under section  
 5 1866A of the Social Security Act, as added by subsection  
 6 (a), is implemented, the Comptroller General of the United  
 7 States shall submit to Congress a report on such dem-  
 8 onstration project. The report shall include such rec-  
 9 ommendations with respect to changes to the demonstra-  
 10 tion project that the Comptroller General determines ap-  
 11 propriate.

12 **SEC. 413. STUDY ON ENROLLMENT PROCEDURES FOR**  
 13 **GROUPS THAT RETAIN INDEPENDENT CON-**  
 14 **TRACTOR PHYSICIANS.**

15 (a) IN GENERAL.—The Comptroller General of the  
 16 United States shall conduct a study of the current medi-  
 17 care enrollment process for groups that retain independent  
 18 contractor physicians with particular emphasis on hos-  
 19 pital-based physicians, such as emergency department  
 20 staffing groups. In conducting the evaluation, the Comp-  
 21 troller General shall consult with groups that retain inde-  
 22 pendent contractor physicians and shall—

23 (1) review the issuance of individual medicare  
 24 provider numbers and the possible medicare program  
 25 integrity vulnerabilities of the current process;



1           (2) review direct and indirect costs associated  
 2           with the current process incurred by the medicare  
 3           program and groups that retain independent con-  
 4           tractor physicians;

5           (3) assess the effect on program integrity by  
 6           the enrollment of groups that retain independent  
 7           contractor hospital-based physicians; and

8           (4) develop suggested procedures for the enroll-  
 9           ment of these groups.

10          (b) REPORT.—Not later than 1 year after the date  
 11          of the enactment of this Act, the Comptroller General shall  
 12          submit to Congress a report on the study conducted under  
 13          subsection (a).

## 14                   **Subtitle C—Other Services**

### 15   **SEC. 421. ONE-YEAR EXTENSION OF MORATORIUM ON** 16                   **THERAPY CAPS; REPORT ON STANDARDS FOR** 17                   **SUPERVISION OF PHYSICAL THERAPY AS-** 18                   **SISTANTS.**

19          (a) IN GENERAL.—Section 1833(g)(4) (42 U.S.C.  
 20   1395l(g)(4)) is amended by striking “2000 and 2001.”  
 21   and inserting “2000, 2001, and 2002.”.

22          (b) CONFORMING AMENDMENT TO CONTINUE FO-  
 23   CUSED MEDICAL REVIEWS OF CLAIMS DURING MORATO-  
 24   RIUM PERIOD.—Section 221(a)(2) of BBRA (113 Stat.

1 1501A–351) is amended by striking “(under the amend-  
2 ment made by paragraph (1)(B))”.

3 (c) STUDY ON STANDARDS FOR SUPERVISION OF  
4 PHYSICAL THERAPIST ASSISTANTS.—

5 (1) STUDY.—The Secretary of Health and  
6 Human Services shall conduct a study of the  
7 implications—

8 (A) of eliminating the “in the room” su-  
9 pervision requirement for medicare payment for  
10 services of physical therapy assistants who are  
11 supervised by physical therapists; and

12 (B) of such requirement on the cap im-  
13 posed under section 1833(g) of the Social Secu-  
14 rity Act (42 U.S.C. 1395l(g)) on physical ther-  
15 apy services.

16 (2) REPORT.—Not later than 18 months after  
17 the date of the enactment of this Act, the Secretary  
18 shall submit to Congress a report on the study con-  
19 ducted under paragraph (1).

20 **SEC. 422. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.**

21 (a) UPDATE.—

22 (1) IN GENERAL.—The last sentence of section  
23 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by  
24 striking “for such services furnished on or after  
25 January 1, 2001, by 1.2 percent” and inserting “for

1 such services furnished on or after January 1, 2001,  
2 by 2.4 percent”.

3 (2) PROHIBITION ON EXCEPTIONS.—

4 (A) IN GENERAL.—Subject to subpara-  
5 graphs (B) and (C), the Secretary of Health  
6 and Human Services may not provide for an ex-  
7 ception under section 1881(b)(7) of the Social  
8 Security Act (42 U.S.C. 1395rr(b)(7)) on or  
9 after December 31, 2000.

10 (B) DEADLINE FOR NEW APPLICATIONS.—

11 In the case of a facility that during 2000 did  
12 not file for an exception rate under such sec-  
13 tion, the facility may submit an application for  
14 an exception rate by not later than July 1,  
15 2001.

16 (C) PROTECTION OF APPROVED EXCEP-

17 TION RATES.—Any exception rate under such  
18 section in effect on December 31, 2000 (or, in  
19 the case of an application under subparagraph  
20 (B), as approved under such application) shall  
21 continue in effect so long as such rate is greater  
22 than the composite rate as updated by the  
23 amendment made by paragraph (1).

24 (b) DEVELOPMENT OF ESRD MARKET BASKET.—

1           (1) DEVELOPMENT.—The Secretary of Health  
2           and Human Services shall collect data and develop  
3           an ESRD market basket whereby the Secretary can  
4           estimate, before the beginning of a year, the percent-  
5           age by which the costs for the year of the mix of  
6           labor and nonlabor goods and services included in  
7           the ESRD composite rate under section 1881(b)(7)  
8           of the Social Security Act (42 U.S.C. 1395rr(b)(7))  
9           will exceed the costs of such mix of goods and serv-  
10          ices for the preceding year. In developing such index,  
11          the Secretary may take into account measures of  
12          changes in—

13                 (A) technology used in furnishing dialysis  
14                 services;

15                 (B) the manner or method of furnishing  
16                 dialysis services; and

17                 (C) the amounts by which the payments  
18                 under such section for all services billed by a  
19                 facility for a year exceed the aggregate allow-  
20                 able audited costs of such services for such fa-  
21                 cility for such year.

22          (2) REPORT.—The Secretary of Health and  
23          Human Services shall submit to Congress a report  
24          on the index developed under paragraph (1) no later  
25          than July 1, 2002, and shall include in the report

1 recommendations on the appropriateness of an an-  
2 nual or periodic update mechanism for renal dialysis  
3 services under the medicare program under title  
4 XVIII of the Social Security Act based on such  
5 index.

6 (c) INCLUSION OF ADDITIONAL SERVICES IN COM-  
7 POSITE RATE.—

8 (1) DEVELOPMENT.—The Secretary of Health  
9 and Human Services shall develop a system which  
10 includes, to the maximum extent feasible, in the  
11 composite rate used for payment under section  
12 1881(b)(7) of the Social Security Act (42 U.S.C.  
13 1395rr(b)(7)), payment for clinical diagnostic lab-  
14 oratory tests and drugs (including drugs paid under  
15 section 1881(b)(11)(B) of such Act (42 U.S.C.  
16 1395rr(b)(11)(B)) that are routinely used in fur-  
17 nishing dialysis services to medicare beneficiaries but  
18 which are currently separately billable by renal dialy-  
19 sis facilities.

20 (2) REPORT.—The Secretary shall include, as  
21 part of the report submitted under subsection (b)(2),  
22 a report on the system developed under paragraph  
23 (1) and recommendations on the appropriateness of  
24 incorporating the system into medicare payment for  
25 renal dialysis services.

1 (d) GAO STUDY ON ACCESS TO SERVICES.—

2 (1) STUDY.—The Comptroller General of the  
3 United States shall study access of medicare bene-  
4 ficiaries to renal dialysis services. Such study shall  
5 include whether there is a sufficient supply of facili-  
6 ties to furnish needed renal dialysis services, whether  
7 medicare payment levels are appropriate, taking into  
8 account audited costs of facilities for all services fur-  
9 nished, to ensure continued access to such services,  
10 and improvements in access (and quality of care)  
11 that may result in the increased use of long nightly  
12 and short daily hemodialysis modalities.

13 (2) REPORT.—Not later than January 1, 2003,  
14 the Comptroller General shall submit to Congress a  
15 report on the study conducted under paragraph (1).

16 (e) SPECIAL RULE FOR PAYMENT FOR 2001.—Not-  
17 withstanding the amendment made by subsection (a)(1),  
18 for purposes of making payments under section 1881(b)  
19 of the Social Security Act (42 U.S.C. 1395rr(b)) for dialy-  
20 sis services furnished during 2001, the composite rate pay-  
21 ment under paragraph (7) of such section—

22 (1) for services furnished on or after January  
23 1, 2001, and before April 1, 2001, shall be the com-  
24 posite rate payment determined under the provisions

1 of law in effect on the day before the date of the en-  
 2 actment of this Act; and

3 (2) for services furnished on or after April 1,  
 4 2001, and before January 1, 2002, shall be the com-  
 5 posite rate payment (as determined taking into ac-  
 6 count the amendment made by subsection (a)(1)) in-  
 7 creased by a transitional percentage allowance equal  
 8 to 0.39 percent (to account for the timing of imple-  
 9 mentation of the CPI update).

10 **SEC. 423. PAYMENT FOR AMBULANCE SERVICES.**

11 (a) RESTORATION OF FULL CPI INCREASE FOR  
 12 2001.—

13 (1) IN GENERAL.—Section 1834(l)(3) (42  
 14 U.S.C. 1395m(l)(3)) is amended by striking “re-  
 15 duced in the case of 2001 and 2002” each place it  
 16 appears and inserting “reduced in the case of  
 17 2002”.

18 (2) SPECIAL RULE FOR PAYMENT FOR 2001.—  
 19 Notwithstanding the amendment made by paragraph  
 20 (1), for purposes of making payments for ambulance  
 21 services under part B of title XVIII of the Social Se-  
 22 curity Act, for services furnished during 2001, the  
 23 “percentage increase in the consumer price index”  
 24 specified in section 1834(l)(3)(B) of such Act (42  
 25 U.S.C. 1395m(l)(3)(B))—

1 (A) for services furnished on or after Jan-  
2 uary 1, 2001, and before July 1, 2001, shall be  
3 the percentage increase for 2001 as determined  
4 under the provisions of law in effect on the day  
5 before the date of the enactment of this Act;  
6 and

7 (B) for services furnished on or after July  
8 1, 2001, and before January 1, 2002, shall be  
9 equal to 4.7 percent.

10 (b) MILEAGE PAYMENTS.—

11 (1) IN GENERAL.—Section 1834(l)(2)(E) (42  
12 U.S.C. 1395m(l)(2)(E)) is amended by inserting be-  
13 fore the period at the end the following: “, except  
14 that such phase-in shall provide for full payment of  
15 any national mileage rate for ambulance services  
16 provided by suppliers that are paid by carriers in  
17 any of the 50 States where payment by a carrier for  
18 such services for all such suppliers in such State did  
19 not, prior to the implementation of the fee schedule,  
20 include a separate amount for all mileage within the  
21 county from which the beneficiary is transported”.

22 (2) EFFECTIVE DATE.—The amendment made  
23 by paragraph (1) shall apply to services furnished on  
24 or after July 1, 2001.



1 **SEC. 424. AMBULATORY SURGICAL CENTERS.**

2 (a) DELAY IN IMPLEMENTATION OF PROSPECTIVE  
3 PAYMENT SYSTEM.—The Secretary of Health and Human  
4 Services may not implement a revised prospective payment  
5 system for services of ambulatory surgical facilities under  
6 section 1833(i) of the Social Security Act (42 U.S.C.  
7 1395l(i)) before January 1, 2002.

8 (b) EXTENDING PHASE-IN TO 4 YEARS.—Section  
9 226 of the BBRA (113 Stat. 1501A–354) is amended by  
10 striking paragraphs (1) and (2) and inserting the fol-  
11 lowing:

12 “(1) in the first year of its implementation,  
13 only a proportion (specified by the Secretary and not  
14 to exceed one-fourth) of the payment for such serv-  
15 ices shall be made in accordance with such system  
16 and the remainder shall be made in accordance with  
17 current regulations; and

18 “(2) in each of the following 2 years a propor-  
19 tion (specified by the Secretary and not to exceed  
20 one-half and three-fourths, respectively) of the pay-  
21 ment for such services shall be made under such sys-  
22 tem and the remainder shall be made in accordance  
23 with current regulations.”.

24 (c) DEADLINE FOR USE OF 1999 OR LATER COST  
25 SURVEYS.—Section 226 of BBRA (113 Stat. 1501A–354)  
26 is amended by adding at the end the following:

1 “By not later than January 1, 2003, the Secretary shall  
2 incorporate data from a 1999 medicare cost survey or a  
3 subsequent cost survey for purposes of implementing or  
4 revising such system.”.

5 **SEC. 425. FULL UPDATE FOR DURABLE MEDICAL EQUIP-**  
6 **MENT.**

7 (a) IN GENERAL.—Section 1834(a)(14) (42 U.S.C.  
8 1395m(a)(14)) is amended—

9 (1) by redesignating subparagraph (D) as sub-  
10 paragraph (F);

11 (2) in subparagraph (C)—

12 (A) by striking “through 2002” and insert-  
13 ing “through 2000”; and

14 (B) by striking “and” at the end; and

15 (3) by inserting after subparagraph (C) the fol-  
16 lowing new subparagraphs:

17 “(D) for 2001, the percentage increase in  
18 the consumer price index for all urban con-  
19 sumers (U.S. city average) for the 12-month  
20 period ending with June 2000;

21 “(E) for 2002, 0 percentage points; and”.

22 (b) SPECIAL RULE FOR PAYMENT FOR 2001.—Not-  
23 withstanding the amendments made by subsection (a), for  
24 purposes of making payments for durable medical equip-  
25 ment under section 1834(a) of the Social Security Act (42

1 U.S.C. 1395m(a)), other than for oxygen and oxygen  
 2 equipment specified in paragraph (9) of such section, the  
 3 payment basis recognized for 2001 under such section—

4 (1) for items furnished on or after January 1,  
 5 2001, and before July 1, 2001, shall be the payment  
 6 basis for 2001 as determined under the provisions of  
 7 law in effect on the day before the date of the enact-  
 8 ment of this Act (including the application of section  
 9 228(a)(1) of BBRA); and

10 (2) for items furnished on or after July 1,  
 11 2001, and before January 1, 2002, shall be the pay-  
 12 ment basis that is determined under such section  
 13 1834(a) if such section 228(a)(1) did not apply and  
 14 taking into account the amendment made by sub-  
 15 section (a), increased by a transitional percentage al-  
 16 lowance equal to 3.28 percent (to account for the  
 17 timing of implementation of the CPI update).

18 **SEC. 426. FULL UPDATE FOR ORTHOTICS AND PROS-**  
 19 **THETICS.**

20 (a) IN GENERAL.—Section 1834(h)(4)(A) (42 U.S.C.  
 21 1395m(h)(4)(A)) is amended—

22 (1) by redesignating clause (vi) as clause (viii);

23 (2) in clause (v)—

24 (A) by striking “through 2002” and insert-  
 25 ing “through 2000”; and

1 (B) by striking “and” at the end; and

2 (3) by inserting after clause (v) the following  
3 new clause:

4 “(vi) for 2001, the percentage in-  
5 crease in the consumer price index for all  
6 urban consumers (U.S. city average) for  
7 the 12-month period ending with June  
8 2000;

9 “(vii) for 2002, 1 percent; and”.

10 (b) SPECIAL RULE FOR PAYMENT FOR 2001.—Not-  
11 withstanding the amendments made by subsection (a), for  
12 purposes of making payments for prosthetic devices and  
13 orthotics and prosthetics (as defined in subparagraphs (B)  
14 and (C) of paragraph (4) of section 1834(h) of the Social  
15 Security Act (42 U.S.C. 1395m(h)) under such section,  
16 the payment basis recognized for 2001 under paragraph  
17 (2) of such section—

18 (1) for items furnished on or after January 1,  
19 2001, and before July 1, 2001, shall be the payment  
20 basis for 2001 as determined under the provisions of  
21 law in effect on the day before the date of the enact-  
22 ment of this Act; and

23 (2) for items furnished on or after July 1,  
24 2001, and before January 1, 2002, shall be the pay-  
25 ment basis that is determined under such section

1 taking into account the amendments made by sub-  
2 section (a), increased by a transitional percentage al-  
3 lowance equal to 2.6 percent (to account for the tim-  
4 ing of implementation of the CPI update).

5 **SEC. 427. ESTABLISHMENT OF SPECIAL PAYMENT PROVI-**  
6 **SIONS AND REQUIREMENTS FOR PROS-**  
7 **THETICS AND CERTAIN CUSTOM-FABRICATED**  
8 **ORTHOTIC ITEMS.**

9 (a) IN GENERAL.—Section 1834(h)(1) (42 U.S.C.  
10 1395m(h)(1)) is amended by adding at the end the fol-  
11 lowing:

12 “(F) SPECIAL PAYMENT RULES FOR CER-  
13 TAIN PROSTHETICS AND CUSTOM-FABRICATED  
14 ORTHOTICS.—

15 “(i) IN GENERAL.—No payment shall  
16 be made under this subsection for an item  
17 of custom-fabricated orthotics described in  
18 clause (ii) or for an item of prosthetics un-  
19 less such item is—

20 “(I) furnished by a qualified  
21 practitioner; and

22 “(II) fabricated by a qualified  
23 practitioner or a qualified supplier at  
24 a facility that meets such criteria as  
25 the Secretary determines appropriate.

1                   “(ii) DESCRIPTION OF CUSTOM-FAB-  
2                   RICATED ITEM.—

3                   “(I) IN GENERAL.—An item de-  
4                   scribed in this clause is an item of  
5                   custom-fabricated orthotics that re-  
6                   quires education, training, and experi-  
7                   ence to custom-fabricate and that is  
8                   included in a list established by the  
9                   Secretary in subclause (II). Such an  
10                  item does not include shoes and shoe  
11                  inserts.

12                  “(II) LIST OF ITEMS.—The Sec-  
13                  retary, in consultation with appro-  
14                  priate experts in orthotics (including  
15                  national organizations representing  
16                  manufacturers of orthotics), shall es-  
17                  tablish and update as appropriate a  
18                  list of items to which this subpara-  
19                  graph applies. No item may be in-  
20                  cluded in such list unless the item is  
21                  individually fabricated for the patient  
22                  over a positive model of the patient.

23                  “(iii) QUALIFIED PRACTITIONER DE-  
24                  FINED.—In this subparagraph, the term

1 ‘qualified practitioner’ means a physician  
2 or other individual who—

3 “(I) is a qualified physical thera-  
4 pist or a qualified occupational thera-  
5 pist;

6 “(II) in the case of a State that  
7 provides for the licensing of orthotics  
8 and prosthetics, is licensed in  
9 orthotics or prosthetics by the State  
10 in which the item is supplied; or

11 “(III) in the case of a State that  
12 does not provide for the licensing of  
13 orthotics and prosthetics, is specifi-  
14 cally trained and educated to provide  
15 or manage the provision of prosthetics  
16 and custom-designed or -fabricated  
17 orthotics, and is certified by the  
18 American Board for Certification in  
19 Orthotics and Prosthetics, Inc. or by  
20 the Board for Orthotist/Prosthetist  
21 Certification, or is credentialed and  
22 approved by a program that the Sec-  
23 retary determines, in consultation  
24 with appropriate experts in orthotics  
25 and prosthetics, has training and edu-

1 cation standards that are necessary to  
 2 provide such prosthetics and orthotics.

3 “(iv) QUALIFIED SUPPLIER DE-  
 4 FINED.—In this subparagraph, the term  
 5 ‘qualified supplier’ means any entity that  
 6 is accredited by the American Board for  
 7 Certification in Orthotics and Prosthetics,  
 8 Inc. or by the Board for Orthotist/Pros-  
 9 thetist Certification, or accredited and ap-  
 10 proved by a program that the Secretary  
 11 determines has accreditation and approval  
 12 standards that are essentially equivalent to  
 13 those of such Board.”.

14 (b) EFFECTIVE DATE.—Not later than 1 year after  
 15 the date of the enactment of this Act, the Secretary of  
 16 Health and Human Services shall promulgate revised reg-  
 17 ulations to carry out the amendment made by subsection  
 18 (a) using a negotiated rulemaking process under sub-  
 19 chapter III of chapter 5 of title 5, United States Code.

20 (c) GAO STUDY AND REPORT.—

21 (1) STUDY.—The Comptroller General of the  
 22 United States shall conduct a study on HCFA Rul-  
 23 ing 96–1, issued on September 1, 1996, with respect  
 24 to distinguishing orthotics from durable medical  
 25 equipment under the medicare program under title



1 XVIII of the Social Security Act. The study shall as-  
2 sess the following matters:

3 (A) The compliance of the Secretary of  
4 Health and Human Services with the Adminis-  
5 trative Procedures Act (under chapter 5 of title  
6 5, United States Code) in making such ruling.

7 (B) The potential impact of such ruling on  
8 the health care furnished to medicare bene-  
9 ficiaries under the medicare program, especially  
10 those beneficiaries with degenerative musculo-  
11 skeletal conditions.

12 (C) The potential for fraud and abuse  
13 under the medicare program if payment were  
14 provided for orthotics used as a component of  
15 durable medical equipment only when made  
16 under the special payment provision for certain  
17 prosthetics and custom-fabricated orthotics  
18 under section 1834(h)(1)(F) of the Social Secu-  
19 rity Act, as added by subsection (a) and fur-  
20 nished by qualified practitioners under that sec-  
21 tion.

22 (D) The impact on payments under titles  
23 XVIII and XIX of the Social Security Act if  
24 such ruling were overturned.

1           (2) REPORT.—Not later than 6 months after  
2           the date of the enactment of this Act, the Comp-  
3           troller General shall submit to Congress a report on  
4           the study conducted under paragraph (1).

5 **SEC. 428. REPLACEMENT OF PROSTHETIC DEVICES AND**  
6 **PARTS.**

7           (a) IN GENERAL.—Section 1834(h)(1) (42 U.S.C.  
8 1395m(h)(1)), as amended by section 427(a), is further  
9 amended by adding at the end the following new subpara-  
10 graph:

11                   “(G) REPLACEMENT OF PROSTHETIC DE-  
12 VICES AND PARTS.—

13                   “(i) IN GENERAL.—Payment shall be  
14 made for the replacement of prosthetic de-  
15 vices which are artificial limbs, or for the  
16 replacement of any part of such devices,  
17 without regard to continuous use or useful  
18 lifetime restrictions if an ordering physi-  
19 cian determines that the provision of a re-  
20 placement device, or a replacement part of  
21 such a device, is necessary because of any  
22 of the following:

23                   “(I) A change in the physio-  
24 logical condition of the patient.

1                   “(II) An irreparable change in  
2                   the condition of the device, or in a  
3                   part of the device.

4                   “(III) The condition of the de-  
5                   vice, or the part of the device, re-  
6                   quires repairs and the cost of such re-  
7                   pairs would be more than 60 percent  
8                   of the cost of a replacement device, or,  
9                   as the case may be, of the part being  
10                  replaced.

11                  “(ii) CONFIRMATION MAY BE RE-  
12                  QUIRED IF DEVICE OR PART BEING RE-  
13                  PLACED IS LESS THAN 3 YEARS OLD.—If a  
14                  physician determines that a replacement  
15                  device, or a replacement part, is necessary  
16                  pursuant to clause (i)—

17                         “(I) such determination shall be  
18                         controlling; and

19                         “(II) such replacement device or  
20                         part shall be deemed to be reasonable  
21                         and necessary for purposes of section  
22                         1862(a)(1)(A);

23                   except that if the device, or part, being re-  
24                   placed is less than 3 years old (calculated  
25                   from the date on which the beneficiary

1           began to use the device or part), the Sec-  
 2           retary may also require confirmation of ne-  
 3           cessity of the replacement device or re-  
 4           placement part, as the case may be.”.

5           (b) PREEMPTION OF RULE.—The provisions of sec-  
 6           tion 1834(h)(1)(G) as added by subsection (a) shall super-  
 7           sede any rule that as of the date of the enactment of this  
 8           Act may have applied a 5-year replacement rule with re-  
 9           gard to prosthetic devices.

10          (c) EFFECTIVE DATE.—The amendment made by  
 11          subsection (a) shall apply to items replaced on or after  
 12          April 1, 2001.

13       **SEC. 429. REVISED PART B PAYMENT FOR DRUGS AND**  
 14               **BIOLOGICALS AND RELATED SERVICES.**

15          (a) RECOMMENDATIONS FOR REVISED PAYMENT  
 16          METHODOLOGY FOR DRUGS AND BIOLOGICALS.—

17               (1) STUDY.—

18                   (A) IN GENERAL.—The Comptroller Gen-  
 19                   eral of the United States shall conduct a study  
 20                   on the reimbursement for drugs and biologicals  
 21                   under the current medicare payment method-  
 22                   ology (provided under section 1842(o) of the  
 23                   Social Security Act (42 U.S.C. 1395u(o))) and  
 24                   for related services under part B of title XVIII

1 of such Act. In the study, the Comptroller Gen-  
2 eral shall—

3 (i) identify the average prices at  
4 which such drugs and biologicals are ac-  
5 quired by physicians and other suppliers;

6 (ii) quantify the difference between  
7 such average prices and the reimbursement  
8 amount under such section; and

9 (iii) determine the extent to which (if  
10 any) payment under such part is adequate  
11 to compensate physicians, providers of  
12 services, or other suppliers of such drugs  
13 and biologicals for costs incurred in the ad-  
14 ministration, handling, or storage of such  
15 drugs or biologicals.

16 (B) CONSULTATION.—In conducting the  
17 study under subparagraph (A), the Comptroller  
18 General shall consult with physicians, providers  
19 of services, and suppliers of drugs and  
20 biologicals under the medicare program under  
21 title XVIII of such Act, as well as other organi-  
22 zations involved in the distribution of such  
23 drugs and biologicals to such physicians, pro-  
24 viders of services, and suppliers.

1           (2) REPORT.—Not later than 9 months after  
2           the date of the enactment of this Act, the Comp-  
3           troller General shall submit to Congress and to the  
4           Secretary of Health and Human Services a report  
5           on the study conducted under this subsection, and  
6           shall include in such report recommendations for re-  
7           vised payment methodologies described in paragraph  
8           (3).

9           (3) RECOMMENDATIONS FOR REVISED PAY-  
10          MENT METHODOLOGIES.—

11           (A) IN GENERAL.—The Comptroller Gen-  
12          eral shall provide specific recommendations for  
13          revised payment methodologies for reimburse-  
14          ment for drugs and biologicals and for related  
15          services under the medicare program. The  
16          Comptroller General may include in the  
17          recommendations—

18           (i) proposals to make adjustments  
19          under subsection (c) of section 1848 of the  
20          Social Security Act (42 U.S.C. 1395w-4)  
21          for the practice expense component of the  
22          physician fee schedule under such section  
23          for the costs incurred in the administra-  
24          tion, handling, or storage of certain cat-

egories of such drugs and biologicals, if appropriate; and

(ii) proposals for new payments to providers of services or suppliers for such costs, if appropriate.

(B) ENSURING PATIENT ACCESS TO CARE.—In making recommendations under this paragraph, the Comptroller General shall ensure that any proposed revised payment methodology is designed to ensure that medicare beneficiaries continue to have appropriate access to health care services under the medicare program.

(C) MATTERS CONSIDERED.—In making recommendations under this paragraph, the Comptroller General shall consider—

(i) the method and amount of reimbursement for similar drugs and biologicals made by large group health plans;

(ii) as a result of any revised payment methodology, the potential for patients to receive inpatient or outpatient hospital services in lieu of services in a physician's office; and

1 (iii) the effect of any revised payment  
2 methodology on the delivery of drug thera-  
3 pies by hospital outpatient departments.

4 (D) COORDINATION WITH BBRA STUDY.—

5 In making recommendations under this para-  
6 graph, the Comptroller General shall conclude  
7 and take into account the results of the study  
8 provided for under section 213(a) of BBRA  
9 (113 Stat. 1501A–350).

10 (b) IMPLEMENTATION OF NEW PAYMENT METHOD-  
11 OLOGY.—

12 (1) IN GENERAL.—Notwithstanding any other  
13 provision of law, based on the recommendations con-  
14 tained in the report under subsection (a), the Sec-  
15 retary of Health and Human Services, subject to  
16 paragraph (2), shall revise the payment methodology  
17 under section 1842(o) of the Social Security Act (42  
18 U.S.C. 1395u(o)) for drugs and biologicals furnished  
19 under part B of the medicare program. To the ex-  
20 tent the Secretary determines appropriate, the Sec-  
21 retary may provide for the adjustments to payments  
22 amounts referred to in subsection (a)(3)(A)(i) or ad-  
23 ditional payments referred to in subsection  
24 (a)(2)(A)(ii).



1           (2) LIMITATION.—In revising the payment  
2       methodology under paragraph (1), in no case may  
3       the estimated aggregate payments for drugs and  
4       biologicals under the revised system (including addi-  
5       tional payments referred to in subsection  
6       (a)(3)(A)(ii)) exceed the aggregate amount of pay-  
7       ment for such drugs and biologicals, as projected by  
8       the Secretary, that would have been made under the  
9       payment methodology in effect under such section  
10      1842(o).

11      (c) MORATORIUM ON DECREASES IN PAYMENT  
12      RATES.—Notwithstanding any other provision of law, ef-  
13      fective for drugs and biologicals furnished on or after Jan-  
14      uary 1, 2001, the Secretary may not directly or indirectly  
15      decrease the rates of reimbursement (in effect as of such  
16      date) for drugs and biologicals under the current medicare  
17      payment methodology (provided under section 1842(o) of  
18      the Social Security Act (42 U.S.C. 1395u(o))) until such  
19      time as the Secretary has reviewed the report submitted  
20      under subsection (a)(2).

21      **SEC. 430. CONTRAST ENHANCED DIAGNOSTIC PROCE-**  
22                                   **DURES UNDER HOSPITAL PROSPECTIVE PAY-**  
23                                   **MENT SYSTEM.**

24      (a) SEPARATE CLASSIFICATION.—Section 1833(t)(2)  
25      (42 U.S.C. 1395l(t)(2)) is amended—

1 (1) by striking “and” at the end of subpara-  
 2 graph (E);

3 (2) by striking the period at the end of sub-  
 4 paragraph (F) and inserting “; and”; and

5 (3) by inserting after subparagraph (F) the fol-  
 6 lowing new subparagraph:

7 “(G) the Secretary shall create additional  
 8 groups of covered OPD services that classify  
 9 separately those procedures that utilize contrast  
 10 agents from those that do not.”.

11 (b) CONFORMING AMENDMENT.—Section 1861(t)(1)  
 12 (42 U.S.C. 1395x(t)(1)) is amended by inserting “(includ-  
 13 ing contrast agents)” after “only such drugs”.

14 (c) EFFECTIVE DATE.—The amendments made by  
 15 this section apply to items and services furnished on or  
 16 after July 1, 2001.

17 **SEC. 431. QUALIFICATIONS FOR COMMUNITY MENTAL**  
 18 **HEALTH CENTERS.**

19 (a) MEDICARE PROGRAM.—Section 1861(ff)(3)(B)  
 20 (42 U.S.C. 1395x(ff)(3)(B)) is amended by striking “enti-  
 21 ty” and all that follows and inserting the following: “entity  
 22 that—

23 “(i)(I) provides the mental health services de-  
 24 scribed in section 1913(c)(1) of the Public Health  
 25 Service Act; or

“(II) in the case of an entity operating in a State that by law precludes the entity from providing itself the service described in subparagraph (E) of such section, provides for such service by contract with an approved organization or entity (as determined by the Secretary);

7 “(ii) meets applicable licensing or certification  
8 requirements for community mental health centers  
9 in the State in which it is located; and

“(iii) meets such additional conditions as the Secretary shall specify to ensure (I) the health and safety of individuals being furnished such services, (II) the effective and efficient furnishing of such services, and (III) the compliance of such entity with the criteria described in section 1931(c)(1) of the Public Health Service Act.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to community mental health centers with respect to services furnished on or after the first day of the third month beginning after the date of the enactment of this Act.

22 SEC. 432. PAYMENT OF PHYSICIAN AND NONPHYSICIAN  
23 SERVICES IN CERTAIN INDIAN PROVIDERS.

24 (a) IN GENERAL.—Section 1880 (42 U.S.C. 1395qq)  
25 is amended—

1           (1) by redesignating subsection (e), as added by  
2           section 3(b)(1) of the Alaska Native and American  
3           Indian Direct Reimbursement Act of 2000 (Public  
4           Law 106–417), as subsection (f); and

5           (2) by inserting after subsection (d) the fol-  
6           lowing new subsection:

7           “(e)(1)(A) Notwithstanding section 1835(d), subject  
8           to subparagraph (B), the Secretary shall make payment  
9           under part B to a hospital or an ambulatory care clinic  
10          (whether provider-based or freestanding) that is operated  
11          by the Indian Health Service or by an Indian tribe or trib-  
12          al organization (as defined for purposes of subsection (a))  
13          for services described in paragraph (2) furnished in or at  
14          the direction of the hospital or clinic under the same situa-  
15          tions, terms, and conditions as would apply if the services  
16          were furnished in or at the direction of such a hospital  
17          or clinic that was not operated by such Service, tribe, or  
18          organization.

19          “(B) Payment shall not be made for services under  
20          subparagraph (A) to the extent that payment is otherwise  
21          made for such services under this title.

22          “(2) The services described in this paragraph are the  
23          following:

24                  “(A) Services for which payment is made under  
25          section 1848.

1           “(B) Services furnished by a practitioner de-  
 2       scribed in section 1842(b)(18)(C) for which payment  
 3       under part B is made under a fee schedule.

4           “(C) Services furnished by a physical therapist  
 5       or occupational therapist as described in section  
 6       1861(p) for which payment under part B is made  
 7       under a fee schedule.

8           “(3) Subsection (c) shall not apply to payments made  
 9       under this subsection.”.

10       (b) CONFORMING AMENDMENTS.—

11           (1)       COVERAGE        AMENDMENT.—Section  
 12       1862(a)(3) (42 U.S.C. 1395y(a)(3)) is amended—

13                   (A) by striking the second comma after  
 14       “1861(aa)(1)”; and

15                   (B) by inserting “in the case of services  
 16       for which payment may be made under section  
 17       1880(e),” after “as defined in section  
 18       1861(aa)(3),”.

19           (2) DIRECT PAYMENT AMENDMENT.—The first  
 20       sentence of section 1842(b)(6) (42 U.S.C.  
 21       1395u(b)(6)) is amended—

22                   (A) by striking “and (F)” and inserting  
 23       “(F)”; and

24                   (B) by inserting before the period the fol-  
 25       lowing: “, and (G) in the case of services in a

1 hospital or clinic to which section 1880(e) ap-  
2 plies, payment shall be made to such hospital or  
3 clinic”.

4 (c) EFFECTIVE DATE.—The amendments made by  
5 this section shall apply to services furnished on or after  
6 July 1, 2001.

7 **SEC. 433. GAO STUDY ON COVERAGE OF SURGICAL FIRST**  
8 **ASSISTING SERVICES OF CERTIFIED REG-**  
9 **ISTERED NURSE FIRST ASSISTANTS.**

10 (a) STUDY.—The Comptroller General of the United  
11 States shall conduct a study on the effect on the medicare  
12 program under title XVIII of the Social Security Act and  
13 on medicare beneficiaries of coverage under the program  
14 of surgical first assisting services of certified registered  
15 nurse first assistants. The Comptroller General shall con-  
16 sider the following when conducting the study:

17 (1) Any impact on the quality of care furnished  
18 to medicare beneficiaries by reason of such coverage.

19 (2) Appropriate education and training require-  
20 ments for certified registered nurse first assistants  
21 who furnish such first assisting services.

22 (3) Appropriate rates of payment under the  
23 program to such certified registered nurse first as-  
24 sistants for furnishing such services, taking into ac-  
25 count the costs of compensation, overhead, and su-

1       pervision attributable to certified registered nurse  
2       first assistants.

3       (b) REPORT.—Not later than 1 year after the date  
4 of the enactment of this Act, the Comptroller General shall  
5 submit to Congress a report on the study conducted under  
6 subsection (a).

7       **SEC. 434. MEDPAC STUDY AND REPORT ON MEDICARE RE-**  
8                               **IMBURSEMENT FOR SERVICES PROVIDED BY**  
9                               **CERTAIN PROVIDERS.**

10       (a) STUDY.—The Medicare Payment Advisory Com-  
11 mission shall conduct a study on the appropriateness of  
12 the current payment rates under the medicare program  
13 under title XVIII of the Social Security Act for services  
14 provided by a—

15               (1) certified nurse-midwife (as defined in sub-  
16 section (gg)(2) of section 1861 of such Act (42  
17 U.S.C. 1395x));

18               (2) physician assistant (as defined in subsection  
19 (aa)(5)(A) of such section);

20               (3) nurse practitioner (as defined in such sub-  
21 section); and

22               (4) clinical nurse specialist (as defined in sub-  
23 section (aa)(5)(B) of such section).

24 The study shall separately examine the appropriateness of  
25 such payment rates for orthopedic physician assistants,

1 taking into consideration the requirements for accredita-  
2 tion, training, and education.

3 (b) REPORT.—Not later than 18 months after the  
4 date of the enactment of this Act, the Commission shall  
5 submit to Congress a report on the study conducted under  
6 subsection (a), together with any recommendations for leg-  
7 islation that the Commission determines to be appropriate  
8 as a result of such study.

9 **SEC. 435. MEDPAC STUDY AND REPORT ON MEDICARE COV-**  
10 **ERAGE OF SERVICES PROVIDED BY CERTAIN**  
11 **NONPHYSICIAN PROVIDERS.**

12 (a) STUDY.—

13 (1) IN GENERAL.—The Medicare Payment Ad-  
14 visory Commission shall conduct a study to deter-  
15 mine the appropriateness of providing coverage  
16 under the medicare program under title XVIII of the  
17 Social Security Act for services provided by a—

18 (A) surgical technologist;

19 (B) marriage counselor;

20 (C) marriage and family therapist;

21 (D) pastoral care counselor; and

22 (E) licensed professional counselor of men-  
23 tal health.

24 (2) COSTS TO PROGRAM.—The study shall con-  
25 sider the short-term and long-term benefits, and



1 costs to the medicare program, of providing the cov-  
2 erage described in paragraph (1).

3 (b) REPORT.—Not later than 18 months after the  
4 date of the enactment of this Act, the Commission shall  
5 submit to Congress a report on the study conducted under  
6 subsection (a), together with any recommendations for leg-  
7 islation that the Commission determines to be appropriate  
8 as a result of such study.

9 **SEC. 436. GAO STUDY AND REPORT ON THE COSTS OF**  
10 **EMERGENCY AND MEDICAL TRANSPOR-**  
11 **TATION SERVICES.**

12 (a) STUDY.—The Comptroller General of the United  
13 States shall conduct a study on the costs of providing  
14 emergency and medical transportation services across the  
15 range of acuity levels of conditions for which such trans-  
16 portation services are provided.

17 (b) REPORT.—Not later than 18 months after the  
18 date of the enactment of this Act, the Comptroller General  
19 shall submit to Congress a report on the study conducted  
20 under subsection (a), together with recommendations for  
21 any changes in methodology or payment level necessary  
22 to fairly compensate suppliers of emergency and medical  
23 transportation services and to ensure the access of bene-  
24 ficiaries under the medicare program under title XVIII of  
25 the Social Security Act.

1 **SEC. 437. GAO STUDIES AND REPORTS ON MEDICARE PAY-**  
2 **MENTS.**

3 (a) GAO STUDY ON HCFA POST-PAYMENT AUDIT  
4 PROCESS.—

5 (1) STUDY.—The Comptroller General of the  
6 United States shall conduct a study on the post-pay-  
7 ment audit process under the medicare program  
8 under title XVIII of the Social Security Act as such  
9 process applies to physicians, including the proper  
10 level of resources that the Health Care Financing  
11 Administration should devote to educating physi-  
12 cians regarding—

- 13 (A) coding and billing;  
14 (B) documentation requirements; and  
15 (C) the calculation of overpayments.

16 (2) REPORT.—Not later than 18 months after  
17 the date of the enactment of this Act, the Comp-  
18 troller General shall submit to Congress a report on  
19 the study conducted under paragraph (1) together  
20 with specific recommendations for changes or im-  
21 provements in the post-payment audit process de-  
22 scribed in such paragraph.

23 (b) GAO STUDY ON ADMINISTRATION AND OVER-  
24 SIGHT.—

25 (1) STUDY.—The Comptroller General of the  
26 United States shall conduct a study on the aggre-

1 gate effects of regulatory, audit, oversight, and pa-  
2 perwork burdens on physicians and other health care  
3 providers participating in the medicare program  
4 under title XVIII of the Social Security Act.

5 (2) REPORT.—Not later than 18 months after  
6 the date of the enactment of this Act, the Comp-  
7 troller General shall submit to Congress a report on  
8 the study conducted under paragraph (1) together  
9 with recommendations regarding any area in  
10 which—

11 (A) a reduction in paperwork, an ease of  
12 administration, or an appropriate change in  
13 oversight and review may be accomplished; or

14 (B) additional payments or education are  
15 needed to assist physicians and other health  
16 care providers in understanding and complying  
17 with any legal or regulatory requirements.

18 **SEC. 438. MEDPAC STUDY ON ACCESS TO OUTPATIENT PAIN**  
19 **MANAGEMENT SERVICES.**

20 (a) STUDY.—The Medicare Payment Advisory Com-  
21 mission shall conduct a study on the barriers to coverage  
22 and payment for outpatient interventional pain medicine  
23 procedures under the medicare program under title XVIII  
24 of the Social Security Act. Such study shall examine—

1           (1) the specific barriers imposed under the  
 2           medicare program on the provision of pain manage-  
 3           ment procedures in hospital outpatient departments,  
 4           ambulatory surgery centers, and physicians’ offices;  
 5           and

6           (2) the consistency of medicare payment poli-  
 7           cies for pain management procedures in those dif-  
 8           ferent settings.

9           (b) REPORT.—Not later than 1 year after the date  
 10          of the enactment of this Act, the Commission shall submit  
 11          to Congress a report on the study.

12                   **TITLE V—PROVISIONS**  
 13                   **RELATING TO PARTS A AND B**  
 14                   **Subtitle A—Home Health Services**  
 15          **SEC. 501. ONE-YEAR ADDITIONAL DELAY IN APPLICATION**  
 16                   **OF 15 PERCENT REDUCTION ON PAYMENT**  
 17                   **LIMITS FOR HOME HEALTH SERVICES.**

18          (a) IN GENERAL.—Section 1895(b)(3)(A)(i) (42  
 19          U.S.C. 1395fff(b)(3)(A)(i)) is amended—

20               (1) by redesignating subclause (II) as subclause  
 21               (III);

22               (2) in subclause (III), as redesignated, by strik-  
 23               ing “described in subclause (I)” and inserting “de-  
 24               scribed in subclause (II)”;

1           (3) by inserting after subclause (I) the fol-  
 2       lowing new subclause:

3                       “(II) For the 12-month period  
 4                       beginning after the period described  
 5                       in subclause (I), such amount (or  
 6                       amounts) shall be equal to the amount  
 7                       (or amounts) determined under sub-  
 8                       clause (I), updated under subpara-  
 9                       graph (B).”.

10       (b) CHANGE IN REPORT.—Section 302(c) of BBRA  
 11 (113 Stat. 1501A–360) is amended—

12           (1) by striking “Not later than” and all that  
 13       follows through “(42 U.S.C. 1395fff)” and inserting  
 14       “Not later than April 1, 2002”; and

15           (2) by striking “Secretary” and inserting  
 16       “Comptroller General of the United States”.

17       (c) CASE MIX ADJUSTMENT CORRECTIONS.—

18           (1) IN GENERAL.—Section 1895(b)(3)(B) (42  
 19       U.S.C. 1395fff(b)(3)(B)) is amended by adding at  
 20       the end the following new clause:

21                       “(iv) ADJUSTMENT FOR CASE MIX  
 22                       CHANGES.—Insofar as the Secretary deter-  
 23                       mines that the adjustments under para-  
 24                       graph (4)(A)(i) for a previous fiscal year  
 25                       (or estimates that such adjustments for a

1 future fiscal year) did (or are likely to) re-  
 2 sult in a change in aggregate payments  
 3 under this subsection during the fiscal year  
 4 that are a result of changes in the coding  
 5 or classification of different units of serv-  
 6 ices that do not reflect real changes in case  
 7 mix, the Secretary may adjust the stand-  
 8 ard prospective payment amount (or  
 9 amounts) under paragraph (3) for subse-  
 10 quent fiscal years so as to eliminate the ef-  
 11 fect of such coding or classification  
 12 changes.”.

13 (2) EFFECTIVE DATE.—The amendment made  
 14 by paragraph (1) shall apply to episodes concluding  
 15 on or after October 1, 2001.

16 **SEC. 502. RESTORATION OF FULL HOME HEALTH MARKET**  
 17 **BASKET UPDATE FOR HOME HEALTH SERV-**  
 18 **ICES FOR FISCAL YEAR 2001.**

19 (a) IN GENERAL.—Section 1861(v)(1)(L)(x) (42  
 20 U.S.C. 1395x(v)(1)(L)(x)) is amended—

21 (1) by striking “2001,”; and

22 (2) by adding at the end the following: “With  
 23 respect to cost reporting periods beginning during  
 24 fiscal year 2001, the update to any limit under this

1       subparagraph shall be the home health market bas-  
2       ket index.”.

3       (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR  
4 2001 BASED ON ADJUSTED PROSPECTIVE PAYMENT  
5 AMOUNTS.—

6           (1) IN GENERAL.—Notwithstanding the amend-  
7       ments made by subsection (a), for purposes of mak-  
8       ing payments under section 1895(b) of the Social  
9       Security Act (42 U.S.C. 1395fff(b)) for home health  
10      services furnished during fiscal year 2001, the Sec-  
11      retary of Health and Human Services shall—

12           (A) with respect to episodes and visits end-  
13      ing on or after October 1, 2000, and before  
14      April 1, 2001, use the final standardized and  
15      budget neutral prospective payment amounts  
16      for 60-day episodes and standardized average  
17      per visit amounts for fiscal year 2001 as pub-  
18      lished by the Secretary in the Federal Register  
19      on July 3, 2000 (65 Fed. Reg. 41128–41214);  
20      and

21           (B) with respect to episodes and visits end-  
22      ing on or after April 1, 2001, and before Octo-  
23      ber 1, 2001, use such amounts increased by 2.2  
24      percent.

1           (2) NO EFFECT ON OTHER PAYMENTS OR DE-  
2       TERMINATIONS.—The Secretary shall not take the  
3       provisions of paragraph (1) into account for pur-  
4       poses of payments, determinations, or budget neu-  
5       trality adjustments under section 1895 of the Social  
6       Security Act.

7   **SEC. 503. TEMPORARY TWO-MONTH PERIODIC INTERIM**  
8           **PAYMENT.**

9       (a) IN GENERAL.—Notwithstanding the amendments  
10   made by section 4603(b) of BBA (42 U.S.C. 1395fff  
11   note), in the case of a home health agency that was receiv-  
12   ing periodic interim payments under section 1815(e)(2) of  
13   the Social Security Act (42 U.S.C. 1395g(e)(2)) as of Sep-  
14   tember 30, 2000, and that is not described in subsection  
15   (b), the Secretary of Health and Human Services shall,  
16   as soon as practicable, make a single periodic interim pay-  
17   ment to such agency in an amount equal to four times  
18   the last full fortnightly periodic interim payment made to  
19   such agency under the payment system in effect prior to  
20   the implementation of the prospective payment system  
21   under section 1895(b) of such Act (42 U.S.C. 1395fff(b)).  
22   Such amount of such periodic interim payment shall be  
23   included in the tentative settlement of the last cost report  
24   for the home health agency under the payment system in  
25   effect prior to the implementation of such prospective pay-



1 ment system, regardless of the ending date of such cost  
2 report.

3 (b) EXCEPTIONS.—The Secretary shall not make an  
4 additional periodic interim payment under subsection (a)  
5 in the case of a home health agency (determined as of  
6 the day that such payment would otherwise be made)  
7 that—

8 (1) notifies the Secretary that such agency does  
9 not want to receive such payment;

10 (2) is not receiving payments pursuant to sec-  
11 tion 405.371 of title 42, Code of Federal Regula-  
12 tions;

13 (3) is excluded from the medicare program  
14 under title XI of the Social Security Act;

15 (4) no longer has a provider agreement under  
16 section 1866 of such Act (42 U.S.C. 1395cc);

17 (5) is no longer in business; or

18 (6) is subject to a court order providing for the  
19 withholding of medicare payments under title XVIII  
20 of such Act.

21 **SEC. 504. USE OF TELEHEALTH IN DELIVERY OF HOME**  
22 **HEALTH SERVICES.**

23 Section 1895 (42 U.S.C. 1395fff) is amended by  
24 adding at the end the following new subsection:

1       “(e) CONSTRUCTION RELATED TO HOME HEALTH  
2 SERVICES.—

3           “(1) TELECOMMUNICATIONS.—Nothing in this  
4 section shall be construed as preventing a home  
5 health agency furnishing a home health unit of serv-  
6 ice for which payment is made under the prospective  
7 payment system established by this section for such  
8 units of service from furnishing services via a tele-  
9 communication system if such services—

10           “(A) do not substitute for in-person home  
11 health services ordered as part of a plan of care  
12 certified by a physician pursuant to section  
13 1814(a)(2)(C) or 1835(a)(2)(A); and

14           “(B) are not considered a home health  
15 visit for purposes of eligibility or payment  
16 under this title.

17           “(2) PHYSICIAN CERTIFICATION.—Nothing in  
18 this section shall be construed as waiving the re-  
19 quirement for a physician certification under section  
20 1814(a)(2)(C) or 1835(a)(2)(A) of such Act (42  
21 U.S.C. 1395f(a)(2)(C), 1395n(a)(2)(A)) for the pay-  
22 ment for home health services, whether or not fur-  
23 nished via a telecommunications system.”.

1 **SEC. 505. STUDY ON COSTS TO HOME HEALTH AGENCIES**  
2 **OF PURCHASING NONROUTINE MEDICAL**  
3 **SUPPLIES.**

4 (a) STUDY.—The Comptroller General of the United  
5 States shall conduct a study on variations in prices paid  
6 by home health agencies furnishing home health services  
7 under the medicare program under title XVIII of the So-  
8 cial Security Act in purchasing nonroutine medical sup-  
9 plies, including ostomy supplies, and volumes of such sup-  
10 plies used, shall determine the effect (if any) of variations  
11 on prices and volumes in the provision of such services.

12 (b) REPORT.—Not later than August 15, 2001, the  
13 Comptroller General shall submit to Congress a report on  
14 the study conducted under subsection (a), and shall in-  
15 clude in the report recommendations respecting whether  
16 payment for nonroutine medical supplies furnished in con-  
17 nection with home health services should be made sepa-  
18 rately from the prospective payment system for such serv-  
19 ices.

20 **SEC. 506. TREATMENT OF BRANCH OFFICES; GAO STUDY**  
21 **ON SUPERVISION OF HOME HEALTH CARE**  
22 **PROVIDED IN ISOLATED RURAL AREAS.**

23 (a) TREATMENT OF BRANCH OFFICES.—

24 (1) IN GENERAL.—Notwithstanding any other  
25 provision of law, in determining for purposes of title  
26 XVIII of the Social Security Act whether an office

1 of a home health agency constitutes a branch office  
2 or a separate home health agency, neither the time  
3 nor distance between a parent office of the home  
4 health agency and a branch office shall be the sole  
5 determinant of a home health agency's branch office  
6 status.

7 (2) CONSIDERATION OF FORMS OF TECH-  
8 NOLOGY IN DEFINITION OF SUPERVISION.—The Sec-  
9 retary of Health and Human Services may include  
10 forms of technology in determining what constitutes  
11 “supervision” for purposes of determining a home  
12 health agency's branch office status under paragraph  
13 (1).

14 (b) GAO STUDY.—

15 (1) STUDY.—The Comptroller General of the  
16 United States shall conduct a study of the provision  
17 of adequate supervision to maintain quality of home  
18 health services delivered under the medicare pro-  
19 gram under title XVIII of the Social Security Act in  
20 isolated rural areas. The study shall evaluate the  
21 methods that home health agency branches and  
22 subunits use to maintain adequate supervision in the  
23 delivery of services to clients residing in those areas,  
24 how these methods of supervision compare to re-  
25 quirements that subunits independently meet medi-

1 care conditions of participation, and the resources  
 2 utilized by subunits to meet such conditions.

3 (2) REPORT.—Not later than January 1, 2002,  
 4 the Comptroller General shall submit to Congress a  
 5 report on the study conducted under paragraph (1).  
 6 The report shall include recommendations on wheth-  
 7 er exceptions are needed for subunits and branches  
 8 of home health agencies under the medicare program  
 9 to maintain access to the home health benefit or  
 10 whether alternative policies should be developed to  
 11 assure adequate supervision and access and rec-  
 12 ommendations on whether a national standard for  
 13 supervision is appropriate.

14 **SEC. 507. CLARIFICATION OF THE HOMEBOUND DEFINI-**  
 15 **TION UNDER THE MEDICARE HOME HEALTH**  
 16 **BENEFIT.**

17 (a) CLARIFICATION.—

18 (1) IN GENERAL.—Sections 1814(a) and  
 19 1835(a) (42 U.S.C. 1395f(a) and 1395n(a)) are  
 20 each amended—

21 (A) in the last sentence, by striking “, and  
 22 that absences of the individual from home are  
 23 infrequent or of relatively short duration, or are  
 24 attributable to the need to receive medical  
 25 treatment”; and

1 (B) by adding at the end the following new  
2 sentences: “Any absence of an individual from  
3 the home attributable to the need to receive  
4 health care treatment, including regular ab-  
5 sences for the purpose of participating in thera-  
6 peutic, psychosocial, or medical treatment in an  
7 adult day-care program that is licensed or cer-  
8 tified by a State, or accredited, to furnish adult  
9 day-care services in the State shall not dis-  
10 qualify an individual from being considered to  
11 be ‘confined to his home’. Any other absence of  
12 an individual from the home shall not so dis-  
13 qualify an individual if the absence is of infre-  
14 quent or of relatively short duration. For pur-  
15 poses of the preceding sentence, any absence for  
16 the purpose of attending a religious service  
17 shall be deemed to be an absence of infrequent  
18 or short duration.”.

19 (2) EFFECTIVE DATE.—The amendments made  
20 by paragraph (1) shall apply to home health services  
21 furnished on or after the date of the enactment of  
22 this Act.

23 (b) STUDY.—

24 (1) IN GENERAL.—The Comptroller General of  
25 the United States shall conduct an evaluation of the

1 effect of the amendment on the cost of and access  
2 to home health services under the medicare program  
3 under title XVIII of the Social Security Act.

4 (2) REPORT.—Not later than 1 year after the  
5 date of the enactment of this Act, the Comptroller  
6 General shall submit to Congress a report on the  
7 study conducted under paragraph (1).

8 **SEC. 508. TEMPORARY INCREASE FOR HOME HEALTH**  
9 **SERVICES FURNISHED IN A RURAL AREA.**

10 (a) 24-MONTH INCREASE BEGINNING APRIL 1,  
11 2001.—In the case of home health services furnished in  
12 a rural area (as defined in section 1886(d)(2)(D) of the  
13 Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) on or  
14 after April 1, 2001, and before April 1, 2003, the Sec-  
15 retary of Health and Human Services shall increase the  
16 payment amount otherwise made under section 1895 of  
17 such Act (42 U.S.C. 1395fff) for such services by 10 per-  
18 cent.

19 (b) WAIVING BUDGET NEUTRALITY.—The Secretary  
20 shall not reduce the standard prospective payment amount  
21 (or amounts) under section 1895 of the Social Security  
22 Act (42 U.S.C. 1395fff) applicable to home health services  
23 furnished during a period to offset the increase in pay-  
24 ments resulting from the application of subsection (a).

## **Subtitle B—Direct Graduate Medical Education**

### **SEC. 511. INCREASE IN FLOOR FOR DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.**

Section 1886(h)(2)(D)(iii) (42 U.S.C. 1395ww(h)(2)(D)(iii)) is amended—

(1) in the heading, by striking “IN FISCAL YEAR 2001 AT 70 PERCENT OF” and inserting “FOR”; and

(2) by inserting after “70 percent” the following: “, and for the cost reporting period beginning during fiscal year 2002 shall not be less than 85 percent,”.

### **SEC. 512. CHANGE IN DISTRIBUTION FORMULA FOR MEDICARE+CHOICE-RELATED NURSING AND ALLIED HEALTH EDUCATION COSTS.**

(a) IN GENERAL.—Section 1886(l)(2)(C) (42 U.S.C. 1395ww(l)(2)(C)) is amended by striking all that follows “multiplied by” and inserting the following: “the ratio of—

“(i) the product of (I) the Secretary’s estimate of the ratio of the amount of payments made under section 1861(v) to the hospital for nursing and allied health education activities for the hospital’s cost reporting period ending in the second pre-



ceding fiscal year, to the hospital's total inpatient days for such period, and (II) the total number of inpatient days (as established by the Secretary) for such period which are attributable to services furnished to individuals who are enrolled under a risk sharing contract with an eligible organization under section 1876 and who are entitled to benefits under part A or who are enrolled with a Medicare+Choice organization under part C; to

“(ii) the sum of the products determined under clause (i) for such cost reporting periods.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to portions of cost reporting periods occurring on or after January 1, 2001.

## **Subtitle C—Changes in Medicare Coverage and Appeals Process**

### **SEC. 521. REVISIONS TO MEDICARE APPEALS PROCESS.**

(a) CONDUCT OF RECONSIDERATIONS OF DETERMINATIONS BY INDEPENDENT CONTRACTORS.—Section 1869 (42 U.S.C. 1395ff) is amended to read as follows:

“DETERMINATIONS; APPEALS

“SEC. 1869. (a) INITIAL DETERMINATIONS.—

1           “(1) PROMULGATIONS OF REGULATIONS.—The  
2       Secretary shall promulgate regulations and make ini-  
3       tial determinations with respect to benefits under  
4       part A or part B in accordance with those regula-  
5       tions for the following:

6           “(A) The initial determination of whether  
7       an individual is entitled to benefits under such  
8       parts.

9           “(B) The initial determination of the  
10      amount of benefits available to the individual  
11      under such parts.

12          “(C) Any other initial determination with  
13      respect to a claim for benefits under such parts,  
14      including an initial determination by the Sec-  
15      retary that payment may not be made, or may  
16      no longer be made, for an item or service under  
17      such parts, an initial determination made by a  
18      utilization and quality control peer review orga-  
19      nization under section 1154(a)(2), and an ini-  
20      tial determination made by an entity pursuant  
21      to a contract (other than a contract under sec-  
22      tion 1852) with the Secretary to administer  
23      provisions of this title or title XI.

24          “(2) DEADLINES FOR MAKING INITIAL DETER-  
25      MINATIONS.—

1           “(A) IN GENERAL.—Subject to subpara-  
2 graph (B), in promulgating regulations under  
3 paragraph (1), initial determinations shall be  
4 concluded by not later than the 45-day period  
5 beginning on the date the fiscal intermediary or  
6 the carrier, as the case may be, receives a claim  
7 for benefits from an individual as described in  
8 paragraph (1). Notice of such determination  
9 shall be mailed to the individual filing the claim  
10 before the conclusion of such 45-day period.

11           “(B) CLEAN CLAIMS.—Subparagraph (A)  
12 shall not apply with respect to any claim that  
13 is subject to the requirements of section  
14 1816(c)(2) or 1842(c)(2).

15           “(3) REDETERMINATIONS.—

16           “(A) IN GENERAL.—In promulgating regu-  
17 lations under paragraph (1) with respect to ini-  
18 tial determinations, such regulations shall pro-  
19 vide for a fiscal intermediary or a carrier to  
20 make a redetermination with respect to a claim  
21 for benefits that is denied in whole or in part.

22           “(B) LIMITATIONS.—

23           “(i) APPEAL RIGHTS.—No initial de-  
24 termination may be reconsidered or ap-  
25 pealed under subsection (b) unless the fis-

1 cal intermediary or carrier has made a re-  
2 determination of that initial determination  
3 under this paragraph.

4 “(ii) DECISIONMAKER.—No redeter-  
5 mination may be made by any individual  
6 involved in the initial determination.

7 “(C) DEADLINES.—

8 “(i) FILING FOR REDETERMINA-  
9 TION.—A redetermination under subpara-  
10 graph (A) shall be available only if notice  
11 is filed with the Secretary to request the  
12 redetermination by not later than the end  
13 of the 120-day period beginning on the  
14 date the individual receives notice of the  
15 initial determination under paragraph (2).

16 “(ii) CONCLUDING REDETERMINA-  
17 TIONS.—Redeterminations shall be con-  
18 cluded by not later than the 30-day period  
19 beginning on the date the fiscal inter-  
20 mediary or the carrier, as the case may be,  
21 receives a request for a redetermination.  
22 Notice of such determination shall be  
23 mailed to the individual filing the claim be-  
24 fore the conclusion of such 30-day period.

1           “(D) CONSTRUCTION.—For purposes of  
2           the succeeding provisions of this section a rede-  
3           termination under this paragraph shall be con-  
4           sidered to be part of the initial determination.

5           “(b) APPEAL RIGHTS.—

6           “(1) IN GENERAL.—

7           “(A) RECONSIDERATION OF INITIAL DE-  
8           TERMINATION.—Subject to subparagraph (D),  
9           any individual dissatisfied with any initial de-  
10          termination under subsection (a)(1) shall be en-  
11          titled to reconsideration of the determination,  
12          and, subject to subparagraphs (D) and (E), a  
13          hearing thereon by the Secretary to the same  
14          extent as is provided in section 205(b) and to  
15          judicial review of the Secretary’s final decision  
16          after such hearing as is provided in section  
17          205(g). For purposes of the preceding sentence,  
18          any reference to the ‘Commissioner of Social  
19          Security’ or the ‘Social Security Administration’  
20          in subsection (g) or (l) of section 205 shall be  
21          considered a reference to the ‘Secretary’ or the  
22          ‘Department of Health and Human Services’,  
23          respectively.

24          “(B) REPRESENTATION BY PROVIDER OR  
25          SUPPLIER.—

1           “(i) IN GENERAL.—Sections 206(a),  
2           1102, and 1871 shall not be construed as  
3           authorizing the Secretary to prohibit an in-  
4           dividual from being represented under this  
5           section by a person that furnishes or sup-  
6           plies the individual, directly or indirectly,  
7           with services or items, solely on the basis  
8           that the person furnishes or supplies the  
9           individual with such a service or item.

10           “(ii) MANDATORY WAIVER OF RIGHT  
11           TO PAYMENT FROM BENEFICIARY.—Any  
12           person that furnishes services or items to  
13           an individual may not represent an indi-  
14           vidual under this section with respect to  
15           the issue described in section 1879(a)(2)  
16           unless the person has waived any rights for  
17           payment from the beneficiary with respect  
18           to the services or items involved in the ap-  
19           peal.

20           “(iii) PROHIBITION ON PAYMENT FOR  
21           REPRESENTATION.—If a person furnishes  
22           services or items to an individual and rep-  
23           resents the individual under this section,  
24           the person may not impose any financial li-

1 ability on such individual in connection  
2 with such representation.

3 “(iv) REQUIREMENTS FOR REP-  
4 REPRESENTATIVES OF A BENEFICIARY.—The  
5 provisions of section 205(j) and of section  
6 206 (other than subsection (a)(4) of such  
7 section) regarding representation of claim-  
8 ants shall apply to representation of an in-  
9 dividual with respect to appeals under this  
10 section in the same manner as they apply  
11 to representation of an individual under  
12 those sections.

13 “(C) SUCCESSION OF RIGHTS IN CASES OF  
14 ASSIGNMENT.—The right of an individual to an  
15 appeal under this section with respect to an  
16 item or service may be assigned to the provider  
17 of services or supplier of the item or service  
18 upon the written consent of such individual  
19 using a standard form established by the Sec-  
20 retary for such an assignment.

21 “(D) TIME LIMITS FOR FILING APPEALS.—

22 “(i) RECONSIDERATIONS.—Reconsid-  
23 eration under subparagraph (A) shall be  
24 available only if the individual described in  
25 subparagraph (A) files notice with the Sec-

1           retary to request reconsideration by not  
2           later than the end of the 180-day period  
3           beginning on the date the individual re-  
4           ceives notice of the redetermination under  
5           subsection (a)(3), or within such additional  
6           time as the Secretary may allow.

7           “(ii) HEARINGS CONDUCTED BY THE  
8           SECRETARY.—The Secretary shall establish  
9           in regulations time limits for the filing of  
10          a request for a hearing by the Secretary in  
11          accordance with provisions in sections 205  
12          and 206.

13          “(E) AMOUNTS IN CONTROVERSY.—

14          “(i) IN GENERAL.—A hearing (by the  
15          Secretary) shall not be available to an indi-  
16          vidual under this section if the amount in  
17          controversy is less than \$100, and judicial  
18          review shall not be available to the indi-  
19          vidual if the amount in controversy is less  
20          than \$1,000.

21          “(ii) AGGREGATION OF CLAIMS.—In  
22          determining the amount in controversy, the  
23          Secretary, under regulations, shall allow  
24          two or more appeals to be aggregated if  
25          the appeals involve—



1 “(I) the delivery of similar or re-  
2 lated services to the same individual  
3 by one or more providers of services  
4 or suppliers, or

5 “(II) common issues of law and  
6 fact arising from services furnished to  
7 two or more individuals by one or  
8 more providers of services or sup-  
9 pliers.

10 “(F) EXPEDITED PROCEEDINGS.—

11 “(i) EXPEDITED DETERMINATION.—

12 In the case of an individual who has re-  
13 ceived notice from a provider of services  
14 that such provider plans—

15 “(I) to terminate services pro-  
16 vided to an individual and a physician  
17 certifies that failure to continue the  
18 provision of such services is likely to  
19 place the individual’s health at signifi-  
20 cant risk, or

21 “(II) to discharge the individual  
22 from the provider of services,  
23 the individual may request, in writing or  
24 orally, an expedited determination or an  
25 expedited reconsideration of an initial de-

1            termination made under subsection (a)(1),  
2            as the case may be, and the Secretary shall  
3            provide such expedited determination or  
4            expedited reconsideration.

5            “(ii) EXPEDITED HEARING.—In a  
6            hearing by the Secretary under this sec-  
7            tion, in which the moving party alleges  
8            that no material issues of fact are in dis-  
9            pute, the Secretary shall make an expe-  
10           dited determination as to whether any such  
11           facts are in dispute and, if not, shall  
12           render a decision expeditiously.

13           “(G) REOPENING AND REVISION OF DE-  
14           TERMINATIONS.—The Secretary may reopen or  
15           revise any initial determination or reconsidered  
16           determination described in this subsection  
17           under guidelines established by the Secretary in  
18           regulations.

19           “(c) CONDUCT OF RECONSIDERATIONS BY INDE-  
20           PENDENT CONTRACTORS.—

21           “(1) IN GENERAL.—The Secretary shall enter  
22           into contracts with qualified independent contractors  
23           to conduct reconsiderations of initial determinations  
24           made under subparagraphs (B) and (C) of sub-  
25           section (a)(1). Contracts shall be for an initial term

1 of three years and shall be renewable on a triennial  
2 basis thereafter.

3 “(2) QUALIFIED INDEPENDENT CON-  
4 TRACTOR.—For purposes of this subsection, the  
5 term ‘qualified independent contractor’ means an en-  
6 tity or organization that is independent of any orga-  
7 nization under contract with the Secretary that  
8 makes initial determinations under subsection  
9 (a)(1), and that meets the requirements established  
10 by the Secretary consistent with paragraph (3).

11 “(3) REQUIREMENTS.—Any qualified inde-  
12 pendent contractor entering into a contract with the  
13 Secretary under this subsection shall meet all of the  
14 following requirements:

15 “(A) IN GENERAL.—The qualified inde-  
16 pendent contractor shall perform such duties  
17 and functions and assume such responsibilities  
18 as may be required by the Secretary to carry  
19 out the provisions of this subsection, and shall  
20 have sufficient training and expertise in medical  
21 science and legal matters to make reconsider-  
22 ations under this subsection.

23 “(B) RECONSIDERATIONS.—

24 “(i) IN GENERAL.—The qualified  
25 independent contractor shall review initial

1 determinations. Where an initial deter-  
2 mination is made with respect to whether  
3 an item or service is reasonable and nec-  
4 essary for the diagnosis or treatment of ill-  
5 ness or injury (under section  
6 1862(a)(1)(A)), such review shall include  
7 consideration of the facts and cir-  
8 cumstances of the initial determination by  
9 a panel of physicians or other appropriate  
10 health care professionals and any decisions  
11 with respect to the reconsideration shall be  
12 based on applicable information, including  
13 clinical experience and medical, technical,  
14 and scientific evidence.

15 “(ii) EFFECT OF NATIONAL AND  
16 LOCAL COVERAGE DETERMINATIONS.—

17 “(I) NATIONAL COVERAGE DE-  
18 TERMINATIONS.—If the Secretary has  
19 made a national coverage determina-  
20 tion pursuant to the requirements es-  
21 tablished under the third sentence of  
22 section 1862(a), such determination  
23 shall be binding on the qualified inde-  
24 pendent contractor in making a deci-

1 sion with respect to a reconsideration  
2 under this section.

3 “(II) LOCAL COVERAGE DETER-  
4 MINATIONS.—If the Secretary has  
5 made a local coverage determination,  
6 such determination shall not be bind-  
7 ing on the qualified independent con-  
8 tractor in making a decision with re-  
9 spect to a reconsideration under this  
10 section. Notwithstanding the previous  
11 sentence, the qualified independent  
12 contractor shall consider the local cov-  
13 erage determination in making such  
14 decision.

15 “(III) ABSENCE OF NATIONAL OR  
16 LOCAL COVERAGE DETERMINATION.—  
17 In the absence of such a national cov-  
18 erage determination or local coverage  
19 determination, the qualified inde-  
20 pendent contractor shall make a deci-  
21 sion with respect to the reconsider-  
22 ation based on applicable information,  
23 including clinical experience and med-  
24 ical, technical, and scientific evidence.

25 “(C) DEADLINES FOR DECISIONS.—

1           “(i) RECONSIDERATIONS.—Except as  
2           provided in clauses (iii) and (iv), the quali-  
3           fied independent contractor shall conduct  
4           and conclude a reconsideration under sub-  
5           paragraph (B), and mail the notice of the  
6           decision with respect to the reconsideration  
7           by not later than the end of the 30-day pe-  
8           riod beginning on the date a request for  
9           reconsideration has been timely filed.

10           “(ii) CONSEQUENCES OF FAILURE TO  
11           MEET DEADLINE.—In the case of a failure  
12           by the qualified independent contractor to  
13           mail the notice of the decision by the end  
14           of the period described in clause (i) or to  
15           provide notice by the end of the period de-  
16           scribed in clause (iii), as the case may be,  
17           the party requesting the reconsideration or  
18           appeal may request a hearing before the  
19           Secretary, notwithstanding any require-  
20           ments for a reconsidered determination for  
21           purposes of the party’s right to such hear-  
22           ing.

23           “(iii) EXPEDITED RECONSIDER-  
24           ATIONS.—The qualified independent con-  
25           tractor shall perform an expedited recon-

sideration under subsection (b)(1)(F) as follows:

“(I) DEADLINE FOR DECISION.—

Notwithstanding section 216(j) and subject to clause (iv), not later than the end of the 72-hour period beginning on the date the qualified independent contractor has received a request for such reconsideration and has received such medical or other records needed for such reconsideration, the qualified independent contractor shall provide notice (by telephone and in writing) to the individual and the provider of services and attending physician of the individual of the results of the reconsideration. Such reconsideration shall be conducted regardless of whether the provider of services or supplier will charge the individual for continued services or whether the individual will be liable for payment for such continued services.

“(II) CONSULTATION WITH BENEFICIARY.—In such reconsideration,

1 the qualified independent contractor  
2 shall solicit the views of the individual  
3 involved.

4 “(III) SPECIAL RULE FOR HOS-  
5 PITAL DISCHARGES.—A reconsider-  
6 ation of a discharge from a hospital  
7 shall be conducted under this clause  
8 in accordance with the provisions of  
9 paragraphs (2), (3), and (4) of section  
10 1154(e) as in effect on the date that  
11 precedes the date of the enactment of  
12 this subparagraph.

13 “(iv) EXTENSION.—An individual re-  
14 questing a reconsideration under this sub-  
15 paragraph may be granted such additional  
16 time as the individual specifies (not to ex-  
17 ceed 14 days) for the qualified independent  
18 contractor to conclude the reconsideration.  
19 The individual may request such additional  
20 time orally or in writing.

21 “(D) LIMITATION ON INDIVIDUAL REVIEW-  
22 ING DETERMINATIONS.—

23 “(i) PHYSICIANS AND HEALTH CARE  
24 PROFESSIONAL.—No physician or health  
25 care professional under the employ of a



1 qualified independent contractor may  
2 review—

3 “(I) determinations regarding  
4 health care services furnished to a pa-  
5 tient if the physician or health care  
6 professional was directly responsible  
7 for furnishing such services; or

8 “(II) determinations regarding  
9 health care services provided in or by  
10 an institution, organization, or agen-  
11 cy, if the physician or any member of  
12 the family of the physician or health  
13 care professional has, directly or indi-  
14 rectly, a significant financial interest  
15 in such institution, organization, or  
16 agency.

17 “(ii) FAMILY DESCRIBED.—For pur-  
18 poses of this paragraph, the family of a  
19 physician or health care professional in-  
20 cludes the spouse (other than a spouse who  
21 is legally separated from the physician or  
22 health care professional under a decree of  
23 divorce or separate maintenance), children  
24 (including stepchildren and legally adopted  
25 children), grandchildren, parents, and

1           grandparents of the physician or health  
2           care professional.

3           “(E) EXPLANATION OF DECISION.—Any  
4           decision with respect to a reconsideration of a  
5           qualified independent contractor shall be in  
6           writing, and shall include a detailed explanation  
7           of the decision as well as a discussion of the  
8           pertinent facts and applicable regulations ap-  
9           plied in making such decision, and in the case  
10          of a determination of whether an item or serv-  
11          ice is reasonable and necessary for the diag-  
12          nosis or treatment of illness or injury (under  
13          section 1862(a)(1)(A)) an explanation of the  
14          medical and scientific rationale for the decision.

15          “(F) NOTICE REQUIREMENTS.—Whenever  
16          a qualified independent contractor makes a de-  
17          cision with respect to a reconsideration under  
18          this subsection, the qualified independent con-  
19          tractor shall promptly notify the entity respon-  
20          sible for the payment of claims under part A or  
21          part B of such decision.

22          “(G) DISSEMINATION OF DECISIONS ON  
23          RECONSIDERATIONS.—Each qualified inde-  
24          pendent contractor shall make available all deci-  
25          sions with respect to reconsiderations of such

1 qualified independent contractors to fiscal inter-  
2 mediaries (under section 1816), carriers (under  
3 section 1842), peer review organizations (under  
4 part B of title XI), Medicare+Choice organiza-  
5 tions offering Medicare+Choice plans under  
6 part C, other entities under contract with the  
7 Secretary to make initial determinations under  
8 part A or part B or title XI, and to the public.  
9 The Secretary shall establish a methodology  
10 under which qualified independent contractors  
11 shall carry out this subparagraph.

12 “(H) ENSURING CONSISTENCY IN DECI-  
13 SIONS.—Each qualified independent contractor  
14 shall monitor its decisions with respect to re-  
15 considerations to ensure the consistency of such  
16 decisions with respect to requests for reconsid-  
17 eration of similar or related matters.

18 “(I) DATA COLLECTION.—

19 “(i) IN GENERAL.—Consistent with  
20 the requirements of clause (ii), a qualified  
21 independent contractor shall collect such  
22 information relevant to its functions, and  
23 keep and maintain such records in such  
24 form and manner as the Secretary may re-  
25 quire to carry out the purposes of this sec-

tion and shall permit access to and use of any such information and records as the Secretary may require for such purposes.

“(ii) TYPE OF DATA COLLECTED.—

Each qualified independent contractor shall keep accurate records of each decision made, consistent with standards established by the Secretary for such purpose. Such records shall be maintained in an electronic database in a manner that provides for identification of the following:

“(I) Specific claims that give rise to appeals.

“(II) Situations suggesting the need for increased education for providers of services, physicians, or suppliers.

“(III) Situations suggesting the need for changes in national or local coverage policy.

“(IV) Situations suggesting the need for changes in local medical review policies.

“(iii) ANNUAL REPORTING.—Each qualified independent contractor shall sub-

mit annually to the Secretary (or otherwise as the Secretary may request) records maintained under this paragraph for the previous year.

“(J) HEARINGS BY THE SECRETARY.—The qualified independent contractor shall (i) prepare such information as is required for an appeal of a decision of the contractor with respect to a reconsideration to the Secretary for a hearing, including as necessary, explanations of issues involved in the decision and relevant policies, and (ii) participate in such hearings as required by the Secretary.

“(4) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—The Secretary shall enter into contracts with not fewer than 12 qualified independent contractors under this subsection.

“(5) LIMITATION ON QUALIFIED INDEPENDENT CONTRACTOR LIABILITY.—No qualified independent contractor having a contract with the Secretary under this subsection and no person who is employed by, or who has a fiduciary relationship with, any such qualified independent contractor or who furnishes professional services to such qualified independent contractor, shall be held by reason of the

1 performance of any duty, function, or activity re-  
2 quired or authorized pursuant to this subsection or  
3 to a valid contract entered into under this sub-  
4 section, to have violated any criminal law, or to be  
5 civilly liable under any law of the United States or  
6 of any State (or political subdivision thereof) pro-  
7 vided due care was exercised in the performance of  
8 such duty, function, or activity.

9 “(d) DEADLINES FOR HEARINGS BY THE SEC-  
10 RETARY.—

11 “(1) HEARING BY ADMINISTRATIVE LAW  
12 JUDGE.—

13 “(A) IN GENERAL.—Except as provided in  
14 subparagraph (B), an administrative law judge  
15 shall conduct and conclude a hearing on a deci-  
16 sion of a qualified independent contractor under  
17 subsection (c) and render a decision on such  
18 hearing by not later than the end of the 90-day  
19 period beginning on the date a request for hear-  
20 ing has been timely filed.

21 “(B) WAIVER OF DEADLINE BY PARTY  
22 SEEKING HEARING.—The 90-day period under  
23 subparagraph (A) shall not apply in the case of  
24 a motion or stipulation by the party requesting  
25 the hearing to waive such period.

1           “(2) DEPARTMENTAL APPEALS BOARD RE-  
2       VIEW.—

3           “(A) IN GENERAL.—The Departmental  
4       Appeals Board of the Department of Health  
5       and Human Services shall conduct and conclude  
6       a review of the decision on a hearing described  
7       in paragraph (1) and make a decision or re-  
8       mand the case to the administrative law judge  
9       for reconsideration by not later than the end of  
10      the 90-day period beginning on the date a re-  
11      quest for review has been timely filed.

12          “(B) DAB HEARING PROCEDURE.—In re-  
13      viewing a decision on a hearing under this para-  
14      graph, the Departmental Appeals Board shall  
15      review the case de novo.

16          “(3) CONSEQUENCES OF FAILURE TO MEET  
17      DEADLINES.—

18          “(A) HEARING BY ADMINISTRATIVE LAW  
19      JUDGE.—In the case of a failure by an adminis-  
20      trative law judge to render a decision by the  
21      end of the period described in paragraph (1),  
22      the party requesting the hearing may request a  
23      review by the Departmental Appeals Board of  
24      the Department of Health and Human Services,  
25      notwithstanding any requirements for a hearing

1           for purposes of the party's right to such a re-  
2           view.

3                   “(B) DEPARTMENTAL APPEALS BOARD RE-  
4           VIEW.—In the case of a failure by the Depart-  
5           mental Appeals Board to render a decision by  
6           the end of the period described in paragraph  
7           (2), the party requesting the hearing may seek  
8           judicial review, notwithstanding any require-  
9           ments for a hearing for purposes of the party's  
10          right to such judicial review.

11          “(e) ADMINISTRATIVE PROVISIONS.—

12                   “(1) LIMITATION ON REVIEW OF CERTAIN REG-  
13          ULATIONS.—A regulation or instruction that relates  
14          to a method for determining the amount of payment  
15          under part B and that was initially issued before  
16          January 1, 1981, shall not be subject to judicial re-  
17          view.

18                   “(2) OUTREACH.—The Secretary shall perform  
19          such outreach activities as are necessary to inform  
20          individuals entitled to benefits under this title and  
21          providers of services and suppliers with respect to  
22          their rights of, and the process for, appeals made  
23          under this section. The Secretary shall use the toll-  
24          free telephone number maintained by the Secretary  
25          under section 1804(b) to provide information re-



1        regarding appeal rights and respond to inquiries re-  
2        garding the status of appeals.

3            “(3) CONTINUING EDUCATION REQUIREMENT  
4        FOR QUALIFIED INDEPENDENT CONTRACTORS AND  
5        ADMINISTRATIVE LAW JUDGES.—The Secretary shall  
6        provide to each qualified independent contractor,  
7        and, in consultation with the Commissioner of Social  
8        Security, to administrative law judges that decide  
9        appeals of reconsiderations of initial determinations  
10       or other decisions or determinations under this sec-  
11       tion, such continuing education with respect to cov-  
12       erage of items and services under this title or poli-  
13       cies of the Secretary with respect to part B of title  
14       XI as is necessary for such qualified independent  
15       contractors and administrative law judges to make  
16       informed decisions with respect to appeals.

17           “(4) REPORTS.—

18           “(A) ANNUAL REPORT TO CONGRESS.—

19        The Secretary shall submit to Congress an an-  
20        nual report describing the number of appeals  
21        for the previous year, identifying issues that re-  
22        quire administrative or legislative actions, and  
23        including any recommendations of the Secretary  
24        with respect to such actions. The Secretary  
25        shall include in such report an analysis of de-

1 terminations by qualified independent contrac-  
2 tors with respect to inconsistent decisions and  
3 an analysis of the causes of any such inconsis-  
4 encies.

5 “(B) SURVEY.—Not less frequently than  
6 every 5 years, the Secretary shall conduct a  
7 survey of a valid sample of individuals entitled  
8 to benefits under this title who have filed ap-  
9 peals of determinations under this section, pro-  
10 viders of services, and suppliers to determine  
11 the satisfaction of such individuals or entities  
12 with the process for appeals of determinations  
13 provided for under this section and education  
14 and training provided by the Secretary with re-  
15 spect to that process. The Secretary shall sub-  
16 mit to Congress a report describing the results  
17 of the survey, and shall include any rec-  
18 ommendations for administrative or legislative  
19 actions that the Secretary determines appro-  
20 priate.”.

21 (b) APPLICABILITY OF REQUIREMENTS AND LIMITA-  
22 TIONS ON LIABILITY OF QUALIFIED INDEPENDENT CON-  
23 TRACTORS TO MEDICARE+CHOICE INDEPENDENT AP-  
24 PEALS CONTRACTORS.—Section 1852(g)(4) (42 U.S.C.  
25 1395w–22(g)(4)) is amended by adding at the end the fol-

1 lowing: “The provisions of section 1869(c)(5) shall apply  
 2 to independent outside entities under contract with the  
 3 Secretary under this paragraph.”.

4 (c) CONFORMING AMENDMENT.—Section 1154(e)  
 5 (42 U.S.C. 1320c–3(e)) is amended by striking para-  
 6 graphs (2), (3), and (4).

7 (d) EFFECTIVE DATE.—The amendments made by  
 8 this section shall apply with respect to initial determina-  
 9 tions made on or after October 1, 2002.

10 **SEC. 522. REVISIONS TO MEDICARE COVERAGE PROCESS.**

11 (a) REVIEW OF DETERMINATIONS.—Section 1869  
 12 (42 U.S.C. 1395ff), as amended by section 521, is further  
 13 amended by adding at the end the following new sub-  
 14 section:

15 “(f) REVIEW OF COVERAGE DETERMINATIONS.—

16 “(1) NATIONAL COVERAGE DETERMINATIONS.—

17 “(A) IN GENERAL.—Review of any na-  
 18 tional coverage determination shall be subject to  
 19 the following limitations:

20 “(i) Such a determination shall not be  
 21 reviewed by any administrative law judge.

22 “(ii) Such a determination shall not  
 23 be held unlawful or set aside on the ground  
 24 that a requirement of section 553 of title  
 25 5, United States Code, or section 1871(b)

1 of this title, relating to publication in the  
2 Federal Register or opportunity for public  
3 comment, was not satisfied.

4 “(iii) Upon the filing of a complaint  
5 by an aggrieved party, such a determina-  
6 tion shall be reviewed by the Departmental  
7 Appeals Board of the Department of  
8 Health and Human Services. In con-  
9 ducting such a review, the Departmental  
10 Appeals Board—

11 “(I) shall review the record and  
12 shall permit discovery and the taking  
13 of evidence to evaluate the reasonable-  
14 ness of the determination, if the  
15 Board determines that the record is  
16 incomplete or lacks adequate informa-  
17 tion to support the validity of the de-  
18 termination;

19 “(II) may, as appropriate, con-  
20 sult with appropriate scientific and  
21 clinical experts; and

22 “(III) shall defer only to the rea-  
23 sonable findings of fact, reasonable in-  
24 terpretations of law, and reasonable

1 applications of fact to law by the Sec-  
2 retary.

3 “(iv) The Secretary shall implement a  
4 decision of the Departmental Appeals  
5 Board within 30 days of receipt of such  
6 decision.

7 “(v) A decision of the Departmental  
8 Appeals Board constitutes a final agency  
9 action and is subject to judicial review.

10 “(B) DEFINITION OF NATIONAL COVERAGE  
11 DETERMINATION.—For purposes of this section,  
12 the term ‘national coverage determination’  
13 means a determination by the Secretary with  
14 respect to whether or not a particular item or  
15 service is covered nationally under this title, but  
16 does not include a determination of what code,  
17 if any, is assigned to a particular item or serv-  
18 ice covered under this title or a determination  
19 with respect to the amount of payment made  
20 for a particular item or service so covered.

21 “(2) LOCAL COVERAGE DETERMINATION.—

22 “(A) IN GENERAL.—Review of any local  
23 coverage determination shall be subject to the  
24 following limitations:

1           “(i) Upon the filing of a complaint by  
2           an aggrieved party, such a determination  
3           shall be reviewed by an administrative law  
4           judge of the Social Security Administra-  
5           tion. The administrative law judge—

6                       “(I) shall review the record and  
7                       shall permit discovery and the taking  
8                       of evidence to evaluate the reasonable-  
9                       ness of the determination, if the ad-  
10                      ministrative law judge determines that  
11                      the record is incomplete or lacks ade-  
12                      quate information to support the va-  
13                      lidity of the determination;

14                     “(II) may, as appropriate, con-  
15                     sult with appropriate scientific and  
16                     clinical experts; and

17                     “(III) shall defer only to the rea-  
18                     sonable findings of fact, reasonable in-  
19                     terpretations of law, and reasonable  
20                     applications of fact to law by the Sec-  
21                     retary.

22           “(ii) Upon the filing of a complaint by  
23           an aggrieved party, a decision of an admin-  
24           istrative law judge under clause (i) shall be  
25           reviewed by the Departmental Appeals

1 Board of the Department of Health and  
2 Human Services.

3 “(iii) The Secretary shall implement a  
4 decision of the administrative law judge or  
5 the Departmental Appeals Board within 30  
6 days of receipt of such decision.

7 “(iv) A decision of the Departmental  
8 Appeals Board constitutes a final agency  
9 action and is subject to judicial review.

10 “(B) DEFINITION OF LOCAL COVERAGE  
11 DETERMINATION.—For purposes of this section,  
12 the term ‘local coverage determination’ means a  
13 determination by a fiscal intermediary or a car-  
14 rier under part A or part B, as applicable, re-  
15 specting whether or not a particular item or  
16 service is covered on an intermediary- or car-  
17 rier-wide basis under such parts, in accordance  
18 with section 1862(a)(1)(A).

19 “(3) NO MATERIAL ISSUES OF FACT IN DIS-  
20 PUTE.—In the case of a determination that may oth-  
21 erwise be subject to review under paragraph  
22 (1)(A)(iii) or paragraph (2)(A)(i), where the moving  
23 party alleges that—

24 “(A) there are no material issues of fact in  
25 dispute, and

1           “(B) the only issue of law is the constitu-  
2           tionality of a provision of this title, or that a  
3           regulation, determination, or ruling by the Sec-  
4           retary is invalid,  
5           the moving party may seek review by a court of com-  
6           petent jurisdiction without filing a complaint under  
7           such paragraph and without otherwise exhausting  
8           other administrative remedies.

9           “(4) PENDING NATIONAL COVERAGE DETER-  
10          MINATIONS.—

11           “(A) IN GENERAL.—In the event the Sec-  
12          retary has not issued a national coverage or  
13          noncoverage determination with respect to a  
14          particular type or class of items or services, an  
15          aggrieved person (as described in paragraph  
16          (5)) may submit to the Secretary a request to  
17          make such a determination with respect to such  
18          items or services. By not later than the end of  
19          the 90-day period beginning on the date the  
20          Secretary receives such a request (notwith-  
21          standing the receipt by the Secretary of new  
22          evidence (if any) during such 90-day period),  
23          the Secretary shall take one of the following ac-  
24          tions:



1                   “(i) Issue a national coverage deter-  
2                   mination, with or without limitations.

3                   “(ii) Issue a national noncoverage de-  
4                   termination.

5                   “(iii) Issue a determination that no  
6                   national coverage or noncoverage deter-  
7                   mination is appropriate as of the end of  
8                   such 90-day period with respect to national  
9                   coverage of such items or services.

10                  “(iv) Issue a notice that states that  
11                  the Secretary has not completed a review  
12                  of the request for a national coverage de-  
13                  termination and that includes an identi-  
14                  fication of the remaining steps in the Sec-  
15                  retary’s review process and a deadline by  
16                  which the Secretary will complete the re-  
17                  view and take an action described in sub-  
18                  clause (I), (II), or (III).

19                  “(B) DEEMED ACTION BY THE SEC-  
20                  RETARY.—In the case of an action described in  
21                  clause (i)(IV), if the Secretary fails to take an  
22                  action referred to in such clause by the deadline  
23                  specified by the Secretary under such clause,  
24                  then the Secretary is deemed to have taken an

1           action described in clause (i)(III) as of the  
2           deadline.

3                   “(C) EXPLANATION OF DETERMINA-  
4           TION.—When issuing a determination under  
5           clause (i), the Secretary shall include an expla-  
6           nation of the basis for the determination. An  
7           action taken under clause (i) (other than sub-  
8           clause (IV)) is deemed to be a national coverage  
9           determination for purposes of review under sub-  
10          paragraph (A).

11                   “(5) STANDING.—An action under this sub-  
12          section seeking review of a national coverage deter-  
13          mination or local coverage determination may be ini-  
14          tiated only by individuals entitled to benefits under  
15          part A, or enrolled under part B, or both, who are  
16          in need of the items or services that are the subject  
17          of the coverage determination.

18                   “(6) PUBLICATION ON THE INTERNET OF DECI-  
19          SIONS OF HEARINGS OF THE SECRETARY.—Each de-  
20          cision of a hearing by the Secretary with respect to  
21          a national coverage determination shall be made  
22          public, and the Secretary shall publish each decision  
23          on the Medicare Internet site of the Department of  
24          Health and Human Services. The Secretary shall re-  
25          move from such decision any information that would

1 identify any individual, provider of services, or sup-  
2 plier.

3 “(7) ANNUAL REPORT ON NATIONAL COVERAGE  
4 DETERMINATIONS.—

5 “(A) IN GENERAL.—Not later than De-  
6 cember 1 of each year, beginning in 2001, the  
7 Secretary shall submit to Congress a report  
8 that sets forth a detailed compilation of the ac-  
9 tual time periods that were necessary to com-  
10 plete and fully implement national coverage de-  
11 terminations that were made in the previous fis-  
12 cal year for items, services, or medical devices  
13 not previously covered as a benefit under this  
14 title, including, with respect to each new item,  
15 service, or medical device, a statement of the  
16 time taken by the Secretary to make and imple-  
17 ment the necessary coverage, coding, and pay-  
18 ment determinations, including the time taken  
19 to complete each significant step in the process  
20 of making and implementing such determina-  
21 tions.

22 “(B) PUBLICATION OF REPORTS ON THE  
23 INTERNET.—The Secretary shall publish each  
24 report submitted under clause (i) on the medi-

1           care Internet site of the Department of Health  
2           and Human Services.

3           “(8) CONSTRUCTION.—Nothing in this sub-  
4           section shall be construed as permitting administra-  
5           tive or judicial review pursuant to this section inso-  
6           far as such review is explicitly prohibited or re-  
7           stricted under another provision of law.”.

8           (b) ESTABLISHMENT OF A PROCESS FOR COVERAGE  
9           DETERMINATIONS.—Section    1862(a)   (42    U.S.C.  
10   1395y(a)) is amended by adding at the end the following  
11   new sentence: “In making a national coverage determina-  
12   tion (as defined in paragraph (1)(B) of section 1869(f))  
13   the Secretary shall ensure that the public is afforded no-  
14   tice and opportunity to comment prior to implementation  
15   by the Secretary of the determination; meetings of advi-  
16   sory committees established under section 1114(f) with  
17   respect to the determination are made on the record; in  
18   making the determination, the Secretary has considered  
19   applicable information (including clinical experience and  
20   medical, technical, and scientific evidence) with respect to  
21   the subject matter of the determination; and in the deter-  
22   mination, provide a clear statement of the basis for the  
23   determination (including responses to comments received  
24   from the public), the assumptions underlying that basis,

1 and make available to the public the data (other than pro-  
2 prietary data) considered in making the determination.”.

3 (c) IMPROVEMENTS TO THE MEDICARE ADVISORY  
4 COMMITTEE PROCESS.—Section 1114 (42 U.S.C. 1314)  
5 is amended by adding at the end the following new sub-  
6 section:

7 “(i)(1) Any advisory committee appointed under sub-  
8 section (f) to advise the Secretary on matters relating to  
9 the interpretation, application, or implementation of sec-  
10 tion 1862(a)(1) shall assure the full participation of a  
11 nonvoting member in the deliberations of the advisory  
12 committee, and shall provide such nonvoting member ac-  
13 cess to all information and data made available to voting  
14 members of the advisory committee, other than informa-  
15 tion that—

16 “(A) is exempt from disclosure pursuant to sub-  
17 section (a) of section 552 of title 5, United States  
18 Code, by reason of subsection (b)(4) of such section  
19 (relating to trade secrets); or

20 “(B) the Secretary determines would present a  
21 conflict of interest relating to such nonvoting mem-  
22 ber.

23 “(2) If an advisory committee described in paragraph  
24 (1) organizes into panels of experts according to types of  
25 items or services considered by the advisory committee,

1 any such panel of experts may report any recommendation  
 2 with respect to such items or services directly to the Sec-  
 3 retary without the prior approval of the advisory com-  
 4 mittee or an executive committee thereof.”.

5 (d) EFFECTIVE DATE.—The amendments made by  
 6 this section shall apply with respect to—

7 (1) a review of any national or local coverage  
 8 determination filed,

9 (2) a request to make such a determination  
 10 made, and

11 (3) a national coverage determination made,  
 12 on or after October 1, 2001.

## 13 **Subtitle D—Improving Access to** 14 **New Technologies**

### 15 **SEC. 531. REIMBURSEMENT IMPROVEMENTS FOR NEW** 16 **CLINICAL LABORATORY TESTS AND DURA-** 17 **BLE MEDICAL EQUIPMENT.**

18 (a) PAYMENT RULE FOR NEW LABORATORY  
 19 TESTS.—Section 1833(h)(4)(B)(viii) (42 U.S.C.  
 20 1395l(h)(4)(B)(viii)) is amended by inserting before the  
 21 period at the end the following: “(or 100 percent of such  
 22 median in the case of a clinical diagnostic laboratory test  
 23 performed on or after January 1, 2001, that the Secretary  
 24 determines is a new test for which no limitation amount

1 has previously been established under this subpara-  
2 graph)''.

3 (b) ESTABLISHMENT OF CODING AND PAYMENT  
4 PROCEDURES FOR NEW CLINICAL DIAGNOSTIC LABORA-  
5 TORY TESTS AND OTHER ITEMS ON A FEE SCHEDULE.—  
6 Not later than 1 year after the date of the enactment of  
7 this Act, the Secretary of Health and Human Services  
8 shall establish procedures for coding and payment deter-  
9 minations for the categories of new clinical diagnostic lab-  
10 oratory tests and new durable medical equipment under  
11 part B of title XVIII of the Social Security Act that per-  
12 mit public consultation in a manner consistent with the  
13 procedures established for implementing coding modifica-  
14 tions for ICD–9–CM.

15 (c) REPORT ON PROCEDURES USED FOR ADVANCED,  
16 IMPROVED TECHNOLOGIES.—Not later than 1 year after  
17 the date of the enactment of this Act, the Secretary of  
18 Health and Human Services shall submit to Congress a  
19 report that identifies the specific procedures used by the  
20 Secretary under part B of title XVIII of the Social Secu-  
21 rity Act to adjust payments for clinical diagnostic labora-  
22 tory tests and durable medical equipment which are classi-  
23 fied to existing codes where, because of an advance in  
24 technology with respect to the test or equipment, there has  
25 been a significant increase or decrease in the resources

1 used in the test or in the manufacture of the equipment,  
2 and there has been a significant improvement in the per-  
3 formance of the test or equipment. The report shall in-  
4 clude such recommendations for changes in law as may  
5 be necessary to assure fair and appropriate payment levels  
6 under such part for such improved tests and equipment  
7 as reflects increased costs necessary to produce improved  
8 results.

9 **SEC. 532. RETENTION OF HCPCS LEVEL III CODES.**

10 (a) IN GENERAL.—The Secretary of Health and  
11 Human Services shall maintain and continue the use of  
12 level III codes of the HCPCS coding system (as such sys-  
13 tem was in effect on August 16, 2000) through December  
14 31, 2003, and shall make such codes available to the pub-  
15 lic.

16 (b) DEFINITION.—For purposes of this section, the  
17 term “HCPCS Level III codes” means the alphanumeric  
18 codes for local use under the Health Care Financing Ad-  
19 ministration Common Procedure Coding System  
20 (HCPCS).

21 **SEC. 533. RECOGNITION OF NEW MEDICAL TECHNOLOGIES**  
22 **UNDER INPATIENT HOSPITAL PPS.**

23 (a) EXPEDITING RECOGNITION OF NEW TECH-  
24 NOLOGIES INTO INPATIENT PPS CODING SYSTEM.—



1           (1) REPORT.—Not later than April 1, 2001, the  
2       Secretary of Health and Human Services shall sub-  
3       mit to Congress a report on methods of expeditiously  
4       incorporating new medical services and technologies  
5       into the clinical coding system used with respect to  
6       payment for inpatient hospital services furnished  
7       under the medicare program under title XVIII of the  
8       Social Security Act, together with a detailed descrip-  
9       tion of the Secretary’s preferred methods to achieve  
10      this purpose.

11          (2) IMPLEMENTATION.—Not later than October  
12      1, 2001, the Secretary shall implement the preferred  
13      methods described in the report transmitted pursu-  
14      ant to paragraph (1).

15      (b) ENSURING APPROPRIATE PAYMENTS FOR HOS-  
16      PITALS INCORPORATING NEW MEDICAL SERVICES AND  
17      TECHNOLOGIES.—

18          (1) ESTABLISHMENT OF MECHANISM.—Section  
19      1886(d)(5) (42 U.S.C. 1395ww(d)(5)) is amended  
20      by adding at the end the following new subpara-  
21      graphs:

22      “(K)(i) Effective for discharges beginning on or after  
23      October 1, 2001, the Secretary shall establish a mecha-  
24      nism to recognize the costs of new medical services and  
25      technologies under the payment system established under

1 this subsection. Such mechanism shall be established after  
2 notice and opportunity for public comment (in the publica-  
3 tions required by subsection (e)(5) for a fiscal year or oth-  
4 erwise).

5 “(ii) The mechanism established pursuant to clause  
6 (i) shall—

7 “(I) apply to a new medical service or tech-  
8 nology if, based on the estimated costs incurred with  
9 respect to discharges involving such service or tech-  
10 nology, the DRG prospective payment rate otherwise  
11 applicable to such discharges under this subsection  
12 is inadequate;

13 “(II) provide for the collection of data with re-  
14 spect to the costs of a new medical service or tech-  
15 nology described in subclause (I) for a period of not  
16 less than two years and not more than three years  
17 beginning on the date on which an inpatient hospital  
18 code is issued with respect to the service or tech-  
19 nology;

20 “(III) subject to paragraph (4)(C)(iii), provide  
21 for additional payment to be made under this sub-  
22 section with respect to discharges involving a new  
23 medical service or technology described in subclause  
24 (I) that occur during the period described in sub-  
25 clause (II) in an amount that adequately reflects the

1       estimated average cost of such service or technology;  
2       and

3           “(IV) provide that discharges involving such a  
4       service or technology that occur after the close of the  
5       period described in subclause (II) will be classified  
6       within a new or existing diagnosis-related group with  
7       a weighting factor under paragraph (4)(B) that is  
8       derived from cost data collected with respect to dis-  
9       charges occurring during such period.

10       “(iii) For purposes of clause (ii)(II), the term ‘inpa-  
11       tient hospital code’ means any code that is used with re-  
12       spect to inpatient hospital services for which payment may  
13       be made under this subsection and includes an alpha-  
14       numeric code issued under the International Classification  
15       of Diseases, 9th Revision, Clinical Modification (‘ICD–9–  
16       CM’) and its subsequent revisions.

17       “(iv) For purposes of clause (ii)(III), the term ‘addi-  
18       tional payment’ means, with respect to a discharge for a  
19       new medical service or technology described in clause  
20       (ii)(I), an amount that exceeds the prospective payment  
21       rate otherwise applicable under this subsection to dis-  
22       charges involving such service or technology that would  
23       be made but for this subparagraph.

24       “(v) The requirement under clause (ii)(III) for an ad-  
25       ditional payment may be satisfied by means of a new-tech-

1 nology group (described in subparagraph (L)), an add-on  
2 payment, a payment adjustment, or any other similar  
3 mechanism for increasing the amount otherwise payable  
4 with respect to a discharge under this subsection. The Sec-  
5 retary may not establish a separate fee schedule for such  
6 additional payment for such services and technologies, by  
7 utilizing a methodology established under subsection (a)  
8 or (h) of section 1834 to determine the amount of such  
9 additional payment, or by other similar mechanisms or  
10 methodologies.

11 “(vi) For purposes of this subparagraph and sub-  
12 paragraph (L), a medical service or technology will be con-  
13 sidered a ‘new medical service or technology’ if the service  
14 or technology meets criteria established by the Secretary  
15 after notice and an opportunity for public comment.

16 “(L)(i) In establishing the mechanism under sub-  
17 paragraph (K), the Secretary may establish new-tech-  
18 nology groups into which a new medical service or tech-  
19 nology will be classified if, based on the estimated average  
20 costs incurred with respect to discharges involving such  
21 service or technology, the DRG prospective payment rate  
22 otherwise applicable to such discharges under this sub-  
23 section is inadequate.

24 “(ii) Such groups—

1           “(I) shall not be based on the costs associated  
2       with a specific new medical service or technology;  
3       but

4           “(II) shall, in combination with the applicable  
5       standardized amounts and the weighting factors as-  
6       signed to such groups under paragraph (4)(B), re-  
7       flect such cost cohorts as the Secretary determines  
8       are appropriate for all new medical services and  
9       technologies that are likely to be provided as inpa-  
10      tient hospital services in a fiscal year.

11       “(iii) The methodology for classifying specific hos-  
12      pital discharges within a diagnosis-related group under  
13      paragraph (4)(A) or a new-technology group shall provide  
14      that a specific hospital discharge may not be classified  
15      within both a diagnosis-related group and a new-tech-  
16      nology group.”.

17           (2) PRIOR CONSULTATION.—The Secretary of  
18      Health and Human Services shall consult with  
19      groups representing hospitals, physicians, and manu-  
20      facturers of new medical technologies before pub-  
21      lishing the notice of proposed rulemaking required  
22      by section 1886(d)(5)(K)(i) of the Social Security  
23      Act (as added by paragraph (1)).

24           (3) CONFORMING AMENDMENT.—Section  
25      1886(d)(4)(C)(i) (42 U.S.C. 1395ww(d)(4)(C)(i)) is

1 amended by striking “technology,” and inserting  
 2 “technology (including a new medical service or  
 3 technology under paragraph (5)(K)),”.

## 4 **Subtitle E—Other Provisions**

### 5 **SEC. 541. INCREASE IN REIMBURSEMENT FOR BAD DEBT.**

6 Section 1861(v)(1)(T) (42 U.S.C. 1395x(v)(1)(T)) is  
 7 amended—

8 (1) in clause (ii), by striking “and” at the end;

9 (2) in clause (iii)—

10 (A) by striking “during a subsequent fiscal  
 11 year” and inserting “during fiscal year 2000”;  
 12 and

13 (B) by striking the period at the end and  
 14 inserting “, and”; and

15 (3) by adding at the end the following new  
 16 clause:

17 “(iv) for cost reporting periods beginning dur-  
 18 ing a subsequent fiscal year, by 30 percent of such  
 19 amount otherwise allowable.”.

### 20 **SEC. 542. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY** 21 **SERVICES UNDER MEDICARE.**

22 (a) IN GENERAL.—When an independent laboratory  
 23 furnishes the technical component of a physician pathol-  
 24 ogy service to a fee-for-service medicare beneficiary who  
 25 is an inpatient or outpatient of a covered hospital, the Sec-

1 retary of Health and Human Services shall treat such  
2 component as a service for which payment shall be made  
3 to the laboratory under section 1848 of the Social Security  
4 Act (42 U.S.C. 1395w-4) and not as an inpatient hospital  
5 service for which payment is made to the hospital under  
6 section 1886(d) of such Act (42 U.S.C. 1395ww(d)) or  
7 as an outpatient hospital service for which payment is  
8 made to the hospital under section 1833(t) of such Act  
9 (42 U.S.C. 1395l(t)).

10 (b) DEFINITIONS.—For purposes of this section:

11 (1) COVERED HOSPITAL.—The term “covered  
12 hospital” means, with respect to an inpatient or an  
13 outpatient, a hospital that had an arrangement with  
14 an independent laboratory that was in effect as of  
15 July 22, 1999, under which a laboratory furnished  
16 the technical component of physician pathology serv-  
17 ices to fee-for-service medicare beneficiaries who  
18 were hospital inpatients or outpatients, respectively,  
19 and submitted claims for payment for such compo-  
20 nent to a medicare carrier (that has a contract with  
21 the Secretary under section 1842 of the Social Secu-  
22 rity Act, 42 U.S.C. 1395u) and not to such hospital.

23 (2) FEE-FOR-SERVICE MEDICARE BENE-  
24 FICIARY.—The term “fee-for-service medicare bene-  
25 ficiary” means an individual who—

1 (A) is entitled to benefits under part A, or  
 2 enrolled under part B, or both, of such title;  
 3 and

4 (B) is not enrolled in any of the following:

5 (i) A Medicare+Choice plan under  
 6 part C of such title.

7 (ii) A plan offered by an eligible orga-  
 8 nization under section 1876 of such Act  
 9 (42 U.S.C. 1395mm).

10 (iii) A program of all-inclusive care  
 11 for the elderly (PACE) under section 1894  
 12 of such Act (42 U.S.C. 1395eee).

13 (iv) A social health maintenance orga-  
 14 nization (SHMO) demonstration project  
 15 established under section 4018(b) of the  
 16 Omnibus Budget Reconciliation Act of  
 17 1987 (Public Law 100–203).

18 (c) EFFECTIVE DATE.—This section shall apply to  
 19 services furnished during the 2-year period beginning on  
 20 January 1, 2001.

21 (d) GAO REPORT.—

22 (1) STUDY.—The Comptroller General of the  
 23 United States shall conduct a study of the effects of  
 24 the previous provisions of this section on hospitals  
 25 and laboratories and access of fee-for-service medi-



1 care beneficiaries to the technical component of phy-  
2 sician pathology services.

3 (2) REPORT.—Not later than April 1, 2002, the  
4 Comptroller General shall submit to Congress a re-  
5 port on such study. The report shall include rec-  
6 ommendations about whether such provisions should  
7 be extended after the end of the period specified in  
8 subsection (c) for either or both inpatient and out-  
9 patient hospital services, and whether the provisions  
10 should be extended to other hospitals.

11 **SEC. 543. EXTENSION OF ADVISORY OPINION AUTHORITY.**

12 Section 1128D(b)(6) (42 U.S.C. 1320a–7d(b)(6)) is  
13 amended by striking “and before the date which is 4 years  
14 after such date of enactment”.

15 **SEC. 544. CHANGE IN ANNUAL MEDPAC REPORTING.**

16 (a) REVISION OF DEADLINES FOR SUBMISSION OF  
17 REPORTS.—

18 (1) IN GENERAL.—Section 1805(b)(1)(D) (42  
19 U.S.C. 1395b–6(b)(1)(D)) is amended by striking  
20 “June 1 of each year (beginning with 1998),” and  
21 inserting “June 15 of each year,”.

22 (2) EFFECTIVE DATE.—The amendment made  
23 by paragraph (1) shall apply beginning with 2001.

24 (b) REQUIREMENT FOR ON THE RECORD VOTES ON  
25 RECOMMENDATIONS.—Section 1805(b) (42 U.S.C.

1 1395b–6(b)) is amended by adding at the end the fol-  
2 lowing new paragraph:

3 “(7) VOTING AND REPORTING REQUIRE-  
4 MENTS.—With respect to each recommendation con-  
5 tained in a report submitted under paragraph (1),  
6 each member of the Commission shall vote on the  
7 recommendation, and the Commission shall include,  
8 by member, the results of that vote in the report  
9 containing the recommendation.”.

10 **SEC. 545. DEVELOPMENT OF PATIENT ASSESSMENT IN-**  
11 **STRUMENTS.**

12 (a) DEVELOPMENT.—

13 (1) IN GENERAL.—Not later than January 1,  
14 2005, the Secretary of Health and Human Services  
15 shall submit to the Committee on Ways and Means  
16 and the Committee on Commerce of the House of  
17 Representatives and the Committee on Finance of  
18 the Senate a report on the development of standard  
19 instruments for the assessment of the health and  
20 functional status of patients, for whom items and  
21 services described in subsection (b) are furnished,  
22 and include in the report a recommendation on the  
23 use of such standard instruments for payment pur-  
24 poses.

1           (2) DESIGN FOR COMPARISON OF COMMON ELE-  
2           MENTS.—The Secretary shall design such standard  
3           instruments in a manner such that—

4                   (A) elements that are common to the items  
5                   and services described in subsection (b) may be  
6                   readily comparable and are statistically compat-  
7                   ible;

8                   (B) only elements necessary to meet pro-  
9                   gram objectives are collected; and

10                  (C) the standard instruments supersede  
11                  any other assessment instrument used before  
12                  that date.

13           (3) CONSULTATION.—In developing an assess-  
14           ment instrument under paragraph (1), the Secretary  
15           shall consult with the Medicare Payment Advisory  
16           Commission, the Agency for Healthcare Research  
17           and Quality, and qualified organizations rep-  
18           resenting providers of services and suppliers under  
19           title XVIII.

20           (b) DESCRIPTION OF SERVICES.—For purposes of  
21           subsection (a), items and services described in this sub-  
22           section are those items and services furnished to individ-  
23           uals entitled to benefits under part A, or enrolled under  
24           part B, or both of title XVIII of the Social Security Act

1 for which payment is made under such title, and include  
2 the following:

3 (1) Inpatient and outpatient hospital services.

4 (2) Inpatient and outpatient rehabilitation serv-  
5 ices.

6 (3) Covered skilled nursing facility services.

7 (4) Home health services.

8 (5) Physical or occupational therapy or speech-  
9 language pathology services.

10 (6) Items and services furnished to such indi-  
11 viduals determined to have end stage renal disease.

12 (7) Partial hospitalization services and other  
13 mental health services.

14 (8) Any other service for which payment is  
15 made under such title as the Secretary determines to  
16 be appropriate.

17 **SEC. 546. GAO REPORT ON IMPACT OF THE EMERGENCY**  
18 **MEDICAL TREATMENT AND ACTIVE LABOR**  
19 **ACT (EMTALA) ON HOSPITAL EMERGENCY DE-**  
20 **PARTMENTS.**

21 (a) REPORT.—The Comptroller General of the  
22 United States shall submit a report to the Committee on  
23 Commerce and the Committee on Ways and Means of the  
24 House of Representatives and the Committee on Finance  
25 of the Senate by May 1, 2001, on the effect of the Emer-

1 gency Medical Treatment and Active Labor Act on hos-  
2 pitals, emergency physicians, and physicians covering  
3 emergency department call throughout the United States.

4 (b) REPORT REQUIREMENTS.—The report should  
5 evaluate—

6 (1) the extent to which hospitals, emergency  
7 physicians, and physicians covering emergency de-  
8 partment call provide uncompensated services in re-  
9 lation to the requirements of EMTALA;

10 (2) the extent to which the regulatory require-  
11 ments and enforcement of EMTALA have expanded  
12 beyond the legislation’s original intent;

13 (3) estimates for the total dollar amount of  
14 EMTALA-related care uncompensated costs to  
15 emergency physicians, physicians covering emer-  
16 gency department call, hospital emergency depart-  
17 ments, and other hospital services;

18 (4) the extent to which different portions of the  
19 United States may be experiencing different levels of  
20 uncompensated EMTALA-related care;

21 (5) the extent to which EMTALA would be  
22 classified as an unfunded mandate if it were enacted  
23 today;

1           (6) the extent to which States have programs to  
2       provide financial support for such uncompensated  
3       care;

4           (7) possible sources of funds, including medi-  
5       care hospital bad debt accounts, that are available to  
6       hospitals to assist with the cost of such uncompen-  
7       sated care; and

8           (8) the financial strain that illegal immigration  
9       populations, the uninsured, and the underinsured  
10      place on hospital emergency departments, other hos-  
11      pital services, emergency physicians, and physicians  
12      covering emergency department call.

13       (c) DEFINITION.—In this section, the terms “Emer-  
14      gency Medical Treatment and Active Labor Act” and  
15      “EMTALA” mean section 1867 of the Social Security Act  
16      (42 U.S.C. 1395dd).

17   **SEC. 547. CLARIFICATION OF APPLICATION OF TEMPORARY**  
18                           **PAYMENT INCREASES FOR 2001.**

19       (a) INPATIENT HOSPITAL SERVICES.—The payment  
20      increase provided under the following sections shall not  
21      apply to discharges occurring after fiscal year 2001 and  
22      shall not be taken into account in calculating the payment  
23      amounts applicable for discharges occurring after such fis-  
24      cal year:

1           (1) Section 301(b)(2)(A) (relating to acute care  
2       hospital payment update).

3           (2) Section 302(b) (relating to IME percentage  
4       adjustment).

5           (3) Section 303(b)(2) (relating to DSH pay-  
6       ments).

7       (b) SKILLED NURSING FACILITY SERVICES.—The  
8       payment increase provided under section 311(b)(2) (relat-  
9       ing to covered skilled nursing facility services) shall not  
10      apply to services furnished after fiscal year 2001 and shall  
11      not be taken into account in calculating the payment  
12      amounts applicable for services furnished after such fiscal  
13      year.

14      (c) HOME HEALTH SERVICES.—

15           (1) TRANSITIONAL ALLOWANCE FOR FULL  
16      MARKETBASKET INCREASE.—The payment increase  
17      provided under section 502(b)(1)(B) shall not apply  
18      to episodes and visits ending after fiscal year 2001  
19      and shall not be taken into account in calculating  
20      the payment amounts applicable for subsequent epi-  
21      sodes and visits.

22           (2) TEMPORARY INCREASE FOR RURAL HOME  
23      HEALTH SERVICES.—The payment increase provided  
24      under section 508(a) for the period beginning on  
25      April 1, 2001, and ending on September 30, 2002,

1       shall not apply to episodes and visits ending after  
2       such period, and shall not be taken into account in  
3       calculating the payment amounts applicable for epi-  
4       sodes and visits occurring after such period.

5       (d) CALENDAR YEAR 2001 PROVISIONS.—The pay-  
6       ment increase provided under the following sections shall  
7       not apply after calendar year 2001 and shall not be taken  
8       into account in calculating the payment amounts applica-  
9       ble for items and services furnished after such year:

10           (1) Section 401(c)(2) (relating to covered OPD  
11       services).

12           (2) Section 422(e)(2) (relating to renal dialysis  
13       services paid for on a composite rate basis).

14           (3) Section 423(a)(2)(B) (relating to ambulance  
15       services).

16           (4) Section 425(b)(2) (relating to durable med-  
17       ical equipment).

18           (5) Section 426(b)(2) (relating to prosthetic de-  
19       vices and orthotics and prosthetics).



1 **TITLE VI—PROVISIONS RELAT-**  
 2 **ING TO PART C**  
 3 **(MEDICARE+CHOICE PRO-**  
 4 **GRAM) AND OTHER MEDI-**  
 5 **CARE MANAGED CARE PROVI-**  
 6 **SIONS**

7 **Subtitle A—Medicare+Choice**  
 8 **Payment Reforms**

9 **SEC. 601. INCREASE IN MINIMUM PAYMENT AMOUNT.**

10 (a) IN GENERAL.—Section 1853(c)(1)(B) (42 U.S.C.  
 11 1395w–23(c)(1)(B)) is amended—

12 (1) by redesignating clause (ii) as clause (iv);

13 (2) by inserting after clause (i) the following  
 14 new clauses:

15 “(ii) For 1999 and 2000, the min-  
 16 imum amount determined under clause (i)  
 17 or this clause, respectively, for the pre-  
 18 ceding year, increased by the national per  
 19 capita Medicare+Choice growth percentage  
 20 described in paragraph (6)(A) applicable to  
 21 1999 or 2000, respectively.

22 “(iii)(I) Subject to subclause (II), for  
 23 2001, for any area in a Metropolitan Sta-  
 24 tistical Area with a population of more

1           than 250,000, \$525, and for any other  
2           area \$475.

3           “(II) In the case of an area outside  
4           the 50 States and the District of Colum-  
5           bia, the amount specified in this clause  
6           shall not exceed 120 percent of the amount  
7           determined under clause (ii) for such area  
8           for 2000.”; and

9           (3) in clause (iv), as so redesignated—

10           (A) by striking “a succeeding year” and  
11           inserting “2002 and each succeeding year”; and

12           (B) by striking “clause (i)” and inserting  
13           “clause (iii)”.

14           (b) SPECIAL RULE FOR JANUARY AND FEBRUARY OF  
15           2001.—

16           (1) IN GENERAL.—Notwithstanding the amend-  
17           ments made by subsection (a), for purposes of mak-  
18           ing payments under section 1853 of the Social Secu-  
19           rity Act (42 U.S.C. 1395w–23) for January and  
20           February 2001, the annual Medicare+Choice capita-  
21           tion rate for a Medicare+Choice payment area shall  
22           be calculated, and the excess amount under section  
23           1854(f)(1)(B) of such Act (42 U.S.C. 1395w–  
24           24(f)(1)(B)) shall be determined, as if such amend-  
25           ments had not been enacted.

1           (2) CONSTRUCTION.—Paragraph (1) shall not  
2       be taken into account in computing such capitation  
3       rate for 2002 and subsequent years.

4 **SEC. 602. INCREASE IN MINIMUM PERCENTAGE INCREASE.**

5       (a) IN GENERAL.—Section 1853(c)(1)(C) (42 U.S.C.  
6 1395w-23(c)(1)(C)) is amended—

7           (1) by redesignating clause (ii) as clause (iv);

8           (2) by inserting after clause (i) the following  
9       new clauses:

10                   “(ii) For 1999 and 2000, 102 percent  
11                   of the annual Medicare+Choice capitation  
12                   rate under this paragraph for the area for  
13                   the previous year.

14                   “(iii) For 2001, 103 percent of the  
15                   annual Medicare+Choice capitation rate  
16                   under this paragraph for the area for  
17                   2000.”; and

18           (3) in clause (iv), as so redesignated, by strik-  
19       ing “a subsequent year” and inserting “2002 and  
20       each succeeding year”.

21       (b) APPLICATION OF SPECIAL RULE FOR JANUARY  
22 AND FEBRUARY OF 2001.—The provisions of section  
23 601(b) shall apply with respect to the amendments made  
24 by subsection (a) in the same manner as they apply to  
25 the amendments made by section 601(a).

1 **SEC. 603. PHASE-IN OF RISK ADJUSTMENT.**

2 Section 1853(a)(3)(C) (42 U.S.C. 1395w–  
3 23(a)(3)(C)) is amended—

4 (1) in clause (ii)—

5 (A) in subclause (I), by striking “and  
6 2001” and inserting “and each succeeding year  
7 through 2003” and by striking “and” at the  
8 end; and

9 (B) by striking subclause (II) and insert-  
10 ing the following new subclauses:

11 “(II) 30 percent of such capita-  
12 tion rate in 2004;

13 “(III) 50 percent of such capita-  
14 tion rate in 2005;

15 “(IV) 75 percent of such capita-  
16 tion rate in 2006; and

17 “(V) 100 percent of such capita-  
18 tion rate in 2007 and succeeding  
19 years.”; and

20 (2) by adding at the end the following new  
21 clause:

22 “(iii) DATA FOR RISK ADJUSTMENT  
23 METHODOLOGY.—Such risk adjustment  
24 methodology for 2004 and each succeeding  
25 year, shall be based on data from inpatient  
26 hospital and ambulatory settings.”.

1 **SEC. 604. TRANSITION TO REVISED MEDICARE+CHOICE**  
2 **PAYMENT RATES.**

3 (a) ANNOUNCEMENT OF REVISED  
4 MEDICARE+CHOICE PAYMENT RATES.—Within 2 weeks  
5 after the date of the enactment of this Act, the Secretary  
6 of Health and Human Services shall determine, and shall  
7 announce (in a manner intended to provide notice to inter-  
8 ested parties) Medicare+Choice capitation rates under  
9 section 1853 of the Social Security Act (42 U.S.C.  
10 1395w–23) for 2001, revised in accordance with the provi-  
11 sions of this Act.

12 (b) REENTRY INTO PROGRAM PERMITTED FOR  
13 MEDICARE+CHOICE PROGRAMS.—A Medicare+Choice  
14 organization that provided notice to the Secretary of  
15 Health and Human Services before the date of the enact-  
16 ment of this Act that it was terminating its contract under  
17 part C of title XVIII of the Social Security Act or was  
18 reducing the service area of a Medicare+Choice plan of-  
19 fered under such part shall be permitted to continue par-  
20 ticipation under such part, or to maintain the service area  
21 of such plan, for 2001 if it submits the Secretary with  
22 the information described in section 1854(a)(1) of the So-  
23 cial Security Act (42 U.S.C. 1395w–24(a)(1)) within 2  
24 weeks after the date revised rates are announced by the  
25 Secretary under subsection (a).

1       (c) REVISED SUBMISSION OF PROPOSED PREMIUMS  
2 AND RELATED INFORMATION.—If—

3           (1) a Medicare+Choice organization provided  
4 notice to the Secretary of Health and Human Serv-  
5 ices as of July 3, 2000, that it was renewing its con-  
6 tract under part C of title XVIII of the Social Secu-  
7 rity Act for all or part of the service area or areas  
8 served under its current contract, and

9           (2) any part of the service area or areas ad-  
10 dressed in such notice includes a payment area for  
11 which the Medicare+Choice capitation rate under  
12 section 1853(c) of such Act (42 U.S.C. 1395w-  
13 23(c)) for 2001, as determined under subsection (a),  
14 is higher than the rate previously determined for  
15 such year,

16 such organization shall revise its submission of the infor-  
17 mation described in section 1854(a)(1) of the Social Secu-  
18 rity Act (42 U.S.C. 1395w-24(a)(1)), and shall submit  
19 such revised information to the Secretary, within 2 weeks  
20 after the date revised rates are announced by the Sec-  
21 retary under subsection (a). In making such submission,  
22 the organization may only reduce beneficiary premiums,  
23 reduce beneficiary cost-sharing, enhance benefits, utilize  
24 the stabilization fund described in section 1854(f)(2) of  
25 such Act (42 U.S.C. 1395w-24(f)(2)), or stabilize or en-

1 hance beneficiary access to providers (so long as such sta-  
 2 bilization or enhancement does not result in increased ben-  
 3 eficiary premiums, increased beneficiary cost-sharing, or  
 4 reduced benefits).

5 (d) WAIVER OF LIMITS ON STABILIZATION FUND.—  
 6 Any regulatory provision that limits the proportion of the  
 7 excess amount that can be withheld in such stabilization  
 8 fund for a contract period shall not apply with respect to  
 9 submissions described in subsections (b) and (c).

10 (e) DISREGARD OF NEW RATE ANNOUNCEMENT IN  
 11 APPLYING PASS-THROUGH FOR NEW NATIONAL COV-  
 12 ERAGE DETERMINATIONS.—For purposes of applying sec-  
 13 tion 1852(a)(5) of the Social Security Act (42 U.S.C.  
 14 1395w–22(a)(5)), the announcement of revised rates  
 15 under subsection (a) shall not be treated as an announce-  
 16 ment under section 1853(b) of such Act (42 U.S.C.  
 17 1395w–23(b)).

18 **SEC. 605. REVISION OF PAYMENT RATES FOR ESRD PA-**  
 19 **TIENTS ENROLLED IN MEDICARE+CHOICE**  
 20 **PLANS.**

21 (a) IN GENERAL.—Section 1853(a)(1)(B) (42 U.S.C.  
 22 1395w–23(a)(1)(B)) is amended by adding at the end the  
 23 following: “In establishing such rates, the Secretary shall  
 24 provide for appropriate adjustments to increase each rate  
 25 to reflect the demonstration rate (including the risk ad-

1 justment methodology associated with such rate) of the  
2 social health maintenance organization end-stage renal  
3 disease capitation demonstrations (established by section  
4 2355 of the Deficit Reduction Act of 1984, as amended  
5 by section 13567(b) of the Omnibus Budget Reconciliation  
6 Act of 1993), and shall compute such rates by taking into  
7 account such factors as renal treatment modality, age, and  
8 the underlying cause of the end-stage renal disease.”.

9       (b) EFFECTIVE DATE.—The amendment made by  
10 subsection (a) shall apply to payments for months begin-  
11 ning with January 2002.

12       (c) PUBLICATION.—Not later than 6 months after  
13 the date of the enactment of this Act, the Secretary of  
14 Health and Human Services shall publish for public com-  
15 ment a description of the appropriate adjustments de-  
16 scribed in the last sentence of section 1853(a)(1)(B) of  
17 the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)),  
18 as added by subsection (a). The Secretary shall publish  
19 such adjustments in final form by not later than July 1,  
20 2001, so that the amendment made by subsection (a) is  
21 implemented on a timely basis consistent with subsection  
22 (b).



1 **SEC. 606. PERMITTING PREMIUM REDUCTIONS AS ADDI-**  
2 **TIONAL BENEFITS UNDER**  
3 **MEDICARE+CHOICE PLANS.**

4 (a) IN GENERAL.—

5 (1) AUTHORIZATION OF PART B PREMIUM RE-  
6 Ductions.—Section 1854(f)(1) (42 U.S.C. 1395w-  
7 24(f)(1)) is amended—

8 (A) by redesignating subparagraph (E) as  
9 subparagraph (F); and

10 (B) by inserting after subparagraph (D)  
11 the following new subparagraph:

12 “(E) PREMIUM REDUCTIONS.—

13 “(i) IN GENERAL.—Subject to clause  
14 (ii), as part of providing any additional  
15 benefits required under subparagraph (A),  
16 a Medicare+Choice organization may elect  
17 a reduction in its payments under section  
18 1853(a)(1)(A) with respect to a  
19 Medicare+Choice plan and the Secretary  
20 shall apply such reduction to reduce the  
21 premium under section 1839 of each en-  
22 rollee in such plan as provided in section  
23 1840(i).

24 “(ii) AMOUNT OF REDUCTION.—The  
25 amount of the reduction under clause (i)

with respect to any enrollee in a Medicare+Choice plan—

“(I) may not exceed 125 percent of the premium described under section 1839(a)(3); and

“(II) shall apply uniformly to each enrollee of the Medicare+Choice plan to which such reduction applies.”.

(2) CONFORMING AMENDMENTS.—

(A) ADJUSTMENT OF PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS.—Section 1853(a)(1)(A) (42 U.S.C. 1395w-23(a)(1)(A)) is amended by inserting “reduced by the amount of any reduction elected under section 1854(f)(1)(E) and” after “for that area,”.

(B) ADJUSTMENT AND PAYMENT OF PART B PREMIUMS.—

(i) ADJUSTMENT OF PREMIUMS.—Section 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by striking “shall” and all that follows and inserting the following: “shall be the amount determined under paragraph (3), adjusted as required in accordance with subsections

1 (b), (c), and (f), and to reflect 80 percent  
2 of any reduction elected under section  
3 1854(f)(1)(E).”.

4 (ii) PAYMENT OF PREMIUMS.—Section  
5 1840 (42 U.S.C. 1395s) is amended by  
6 adding at the end the following new sub-  
7 section:

8 “(i) In the case of an individual enrolled in a  
9 Medicare+Choice plan, the Secretary shall provide for  
10 necessary adjustments of the monthly beneficiary pre-  
11 mium to reflect 80 percent of any reduction elected under  
12 section 1854(f)(1)(E). To the extent to which the Sec-  
13 retary determines that such an adjustment is appropriate,  
14 with the concurrence of any agency responsible for the ad-  
15 ministration of such benefits, such premium adjustment  
16 may be provided directly, as an adjustment to any social  
17 security, railroad retirement, or civil service retirement  
18 benefits, or, in the case of an individual who receives med-  
19 ical assistance under title XIX for medicare costs de-  
20 scribed in section 1905(p)(3)(A)(ii), as an adjustment to  
21 the amount otherwise owed by the State for such medical  
22 assistance.”.

23 (C) INFORMATION COMPARING PLAN PRE-  
24 MIUMS UNDER PART C.—Section 1851(d)(4)(B)  
25 (42 U.S.C. 1395w–21(d)(4)(B)) is amended—

1 (i) by striking “PREMIUMS.—The”  
 2 and inserting “PREMIUMS.—

3 “(i) IN GENERAL.—The”; and

4 (ii) by adding at the end the following  
 5 new clause:

6 “(ii) REDUCTIONS.—The reduction in  
 7 part B premiums, if any.”.

8 (D) TREATMENT OF REDUCTION FOR PUR-  
 9 POSES OF DETERMINING GOVERNMENT CON-  
 10 TRIBUTION UNDER PART B.—Section 1844 (42  
 11 U.S.C. 1395w) is amended by adding at the  
 12 end the following new subsection:

13 “(c) The Secretary shall determine the Government  
 14 contribution under subparagraphs (A) and (B) of sub-  
 15 section (a)(1) without regard to any premium reduction  
 16 resulting from an election under section 1854(f)(1)(E).”.

17 (b) EFFECTIVE DATE.—The amendments made by  
 18 subsection (a) shall apply to years beginning with 2003.

19 **SEC. 607. FULL IMPLEMENTATION OF RISK ADJUSTMENT**  
 20 **FOR CONGESTIVE HEART FAILURE ENROLL-**  
 21 **EES FOR 2001.**

22 (a) IN GENERAL.—Section 1853(a)(3)(C) (42 U.S.C.  
 23 1395w–23(a)(3)(C)) is amended—

1           (1) in clause (ii), by striking “Such risk adjust-  
2       ment” and inserting “Except as provided in clause  
3       (iii), such risk adjustment”; and

4           (2) by adding at the end the following new  
5       clause:

6                       “(iii) FULL IMPLEMENTATION OF  
7                       RISK ADJUSTMENT FOR CONGESTIVE  
8                       HEART FAILURE ENROLLEES FOR 2001.—

9                       “(I) EXEMPTION FROM PHASE-  
10                      IN.—Subject to subclause (II), the  
11                      Secretary shall fully implement the  
12                      risk adjustment methodology de-  
13                      scribed in clause (i) with respect to  
14                      each individual who has had a quali-  
15                      fying congestive heart failure inpa-  
16                      tient diagnosis (as determined by the  
17                      Secretary under such risk adjustment  
18                      methodology) during the period begin-  
19                      ning on July 1, 1999, and ending on  
20                      June 30, 2000, and who is enrolled in  
21                      a coordinated care plan that is the  
22                      only coordinated care plan offered on  
23                      January 1, 2001, in the service area  
24                      of the individual.

1 “(II) PERIOD OF APPLICATION.—  
2 Subclause (I) shall only apply during  
3 the 1-year period beginning on Janu-  
4 ary 1, 2001.”.

5 (b) EXCLUSION FROM DETERMINATION OF THE  
6 BUDGET NEUTRALITY FACTOR.—Section 1853(c)(5) (42  
7 U.S.C. 1395w–23(c)(5)) is amended by striking “sub-  
8 section (i)” and inserting “subsections (a)(3)(C)(iii) and  
9 (i)”.

10 **SEC. 608. EXPANSION OF APPLICATION OF**  
11 **MEDICARE+CHOICE NEW ENTRY BONUS.**

12 (a) IN GENERAL.—Section 1853(i)(1) (42 U.S.C.  
13 1395w–23(i)(1)) is amended in the matter preceding sub-  
14 paragraph (A) by inserting “, or filed notice with the Sec-  
15 retary as of October 3, 2000, that they will not be offering  
16 such a plan as of January 1, 2001” after “January 1,  
17 2000”.

18 (b) EFFECTIVE DATE.—The amendment made by  
19 subsection (a) shall apply as if included in the enactment  
20 of BBRA.

1 **SEC. 609. REPORT ON INCLUSION OF CERTAIN COSTS OF**  
2 **THE DEPARTMENT OF VETERANS AFFAIRS**  
3 **AND MILITARY FACILITY SERVICES IN CAL-**  
4 **CULATING MEDICARE+CHOICE PAYMENT**  
5 **RATES.**

6 The Secretary of Health and Human Services shall  
7 report to Congress by not later than January 1, 2003,  
8 on a method to phase-in the costs of military facility serv-  
9 ices furnished by the Department of Veterans Affairs, and  
10 the costs of military facility services furnished by the De-  
11 partment of Defense, to medicare-eligible beneficiaries in  
12 the calculation of an area's Medicare+Choice capitation  
13 payment. Such report shall include on a county-by-county  
14 basis—

15 (1) the actual or estimated cost of such services  
16 to medicare-eligible beneficiaries;

17 (2) the change in Medicare+Choice capitation  
18 payment rates if such costs are included in the cal-  
19 culation of payment rates;

20 (3) one or more proposals for the implementa-  
21 tion of payment adjustments to Medicare+Choice  
22 plans in counties where the payment rate has been  
23 affected due to the failure to calculate the cost of  
24 such services to medicare-eligible beneficiaries; and

25 (4) a system to ensure that when a  
26 Medicare+Choice enrollee receives covered services

1 through a facility of the Department of Veterans Af-  
 2 fairs or the Department of Defense there is an ap-  
 3 propriate payment recovery to the medicare program  
 4 under title XVIII of the Social Security Act.

## 5 **Subtitle B—Other Medicare+Choice** 6 **Reforms**

### 7 **SEC. 611. PAYMENT OF ADDITIONAL AMOUNTS FOR NEW** 8 **BENEFITS COVERED DURING A CONTRACT** 9 **TERM.**

10 (a) IN GENERAL.—Section 1853(c)(7) (42 U.S.C.  
 11 1395w–23(c)(7)) is amended to read as follows:

12 “(7) ADJUSTMENT FOR NATIONAL COVERAGE  
 13 DETERMINATIONS AND LEGISLATIVE CHANGES IN  
 14 BENEFITS.—If the Secretary makes a determination  
 15 with respect to coverage under this title or there is  
 16 a change in benefits required to be provided under  
 17 this part that the Secretary projects will result in a  
 18 significant increase in the costs to Medicare+Choice  
 19 of providing benefits under contracts under this part  
 20 (for periods after any period described in section  
 21 1852(a)(5)), the Secretary shall adjust appropriately  
 22 the payments to such organizations under this part.  
 23 Such projection and adjustment shall be based on an  
 24 analysis by the Chief Actuary of the Health Care Fi-



1       nancing Administration of the actuarial costs associ-  
2       ated with the new benefits.”.

3       (b) CONFORMING AMENDMENT.—Section 1852(a)(5)  
4       (42 U.S.C. 1395w–22(a)(5)) is amended—

5               (1) in the heading, by inserting “AND LEGISLA-  
6       TIVE CHANGES IN BENEFITS” after “NATIONAL COV-  
7       ERAGE DETERMINATIONS”;

8               (2) by inserting “or legislative change in bene-  
9       fits required to be provided under this part” after  
10       “national coverage determination”;

11              (3) in subparagraph (A), by inserting “or legis-  
12       lative change in benefits” after “such determina-  
13       tion”;

14              (4) in subparagraph (B), by inserting “or legis-  
15       lative change” after “if such coverage determina-  
16       tion”; and

17              (5) by adding at the end the following:

18       “The projection under the previous sentence shall be  
19       based on an analysis by the Chief Actuary of the  
20       Health Care Financing Administration of the actu-  
21       arial costs associated with the coverage determina-  
22       tion or legislative change in benefits.”.

23       (c) EFFECTIVE DATE.—The amendments made by  
24       this section are effective on the date of the enactment of  
25       this Act and shall apply to national coverage determina-

1 tions and legislative changes in benefits occurring on or  
2 after such date.

3 **SEC. 612. RESTRICTION ON IMPLEMENTATION OF SIGNIFI-**  
4 **CANT NEW REGULATORY REQUIREMENTS**  
5 **MIDYEAR.**

6 (a) IN GENERAL.—Section 1856(b) (42 U.S.C.  
7 1395w–26(b)) is amended by adding at the end the fol-  
8 lowing new paragraph:

9 “(4) PROHIBITION OF MIDYEAR IMPLEMENTA-  
10 TION OF SIGNIFICANT NEW REGULATORY REQUIRE-  
11 MENTS.—The Secretary may not implement, other  
12 than at the beginning of a calendar year, regulations  
13 under this section that impose new, significant regu-  
14 latory requirements on a Medicare+Choice organiza-  
15 tion or plan.”.

16 (b) EFFECTIVE DATE.—The amendment made by  
17 subsection (a) takes effect on the date of the enactment  
18 of this Act.

19 **SEC. 613. TIMELY APPROVAL OF MARKETING MATERIAL**  
20 **THAT FOLLOWS MODEL MARKETING LAN-**  
21 **GUAGE.**

22 (a) IN GENERAL.—Section 1851(h) (42 U.S.C.  
23 1395w–21(h)) is amended—

1           (1) in paragraph (1)(A), by inserting “(or 10  
2       days in the case described in paragraph (5))” after  
3       “45 days”; and

4           (2) by adding at the end the following new  
5       paragraph:

6           “(5) SPECIAL TREATMENT OF MARKETING MA-  
7       TERIAL FOLLOWING MODEL MARKETING LAN-  
8       GUAGE.—In the case of marketing material of an or-  
9       ganization that uses, without modification, proposed  
10      model language specified by the Secretary, the pe-  
11      riod specified in paragraph (1)(A) shall be reduced  
12      from 45 days to 10 days.”.

13       (b) EFFECTIVE DATE.—The amendments made by  
14      subsection (a) shall apply to marketing material submitted  
15      on or after January 1, 2001.

16   **SEC. 614. AVOIDING DUPLICATIVE REGULATION.**

17       (a) IN GENERAL.—Section 1856(b)(3)(B) (42 U.S.C.  
18      1395w-26(b)(3)(B)) is amended—

19           (1) in clause (i), by inserting “(including cost-  
20      sharing requirements)” after “Benefit require-  
21      ments”; and

22           (2) by adding at the end the following new  
23      clause:

24                           “(iv) Requirements relating to mar-  
25                           keting materials and summaries and sched-

1                   ules       of       benefits       regarding       a  
2                   Medicare+Choice plan.”.

3       (b) EFFECTIVE DATE.—The amendments made by  
4 subsection (a) take effect on the date of the enactment  
5 of this Act.

6 **SEC. 615. ELECTION OF UNIFORM LOCAL COVERAGE POL-**  
7 **ICY FOR MEDICARE+CHOICE PLAN COVERING**  
8 **MULTIPLE LOCALITIES.**

9       Section 1852(a)(2) (42 U.S.C. 1395w–22(a)(2)) is  
10 amended by adding at the end the following new subpara-  
11 graph:

12                   “(C) ELECTION OF UNIFORM COVERAGE  
13 POLICY.—In the case of a Medicare+Choice or-  
14 ganization that offers a Medicare+Choice plan  
15 in an area in which more than one local cov-  
16 erage policy is applied with respect to different  
17 parts of the area, the organization may elect to  
18 have the local coverage policy for the part of  
19 the area that is most beneficial to  
20 Medicare+Choice enrollees (as identified by the  
21 Secretary) apply with respect to all  
22 Medicare+Choice enrollees enrolled in the  
23 plan.”.

1 **SEC. 616. ELIMINATING HEALTH DISPARITIES IN**  
2 **MEDICARE+CHOICE PROGRAM.**

3 (a) QUALITY ASSURANCE PROGRAM FOCUS ON RA-  
4 CIAL AND ETHNIC MINORITIES.—Subparagraphs (A) and  
5 (B) of section 1852(e)(2) (42 U.S.C. 1395w–22(e)(2)) are  
6 each amended by adding at the end the following:

7 “Such program shall include a separate focus  
8 (with respect to all the elements described in  
9 this subparagraph) on racial and ethnic minori-  
10 ties.”.

11 (b) REPORT.—Section 1852(e) (42 U.S.C. 1395w–  
12 22(e)) is amended by adding at the end the following new  
13 paragraph:

14 “(5) REPORT TO CONGRESS.—

15 “(A) IN GENERAL.—Not later than 2 years  
16 after the date of the enactment of this para-  
17 graph, and biennially thereafter, the Secretary  
18 shall submit to Congress a report regarding  
19 how quality assurance programs conducted  
20 under this subsection focus on racial and ethnic  
21 minorities.

22 “(B) CONTENTS OF REPORT.—Each such  
23 report shall include the following:

24 “(i) A description of the means by  
25 which such programs focus on such racial  
26 and ethnic minorities.

1                   “(ii) An evaluation of the impact of  
 2                   such programs on eliminating health dis-  
 3                   parities and on improving health outcomes,  
 4                   continuity and coordination of care, man-  
 5                   agement of chronic conditions, and con-  
 6                   sumer satisfaction.

7                   “(iii) Recommendations on ways to re-  
 8                   duce clinical outcome disparities among ra-  
 9                   cial and ethnic minorities.”.

10 **SEC. 617. MEDICARE+CHOICE PROGRAM COMPATIBILITY**  
 11 **WITH EMPLOYER OR UNION GROUP HEALTH**  
 12 **PLANS.**

13           (a) IN GENERAL.—Section 1857 (42 U.S.C. 1395w-  
 14 27) is amended by adding at the end the following new  
 15 subsection:

16           “(i) MEDICARE+CHOICE PROGRAM COMPATIBILITY  
 17 WITH EMPLOYER OR UNION GROUP HEALTH PLANS.—  
 18 To facilitate the offering of Medicare+Choice plans under  
 19 contracts between Medicare+Choice organizations and  
 20 employers, labor organizations, or the trustees of a fund  
 21 established by one or more employers or labor organiza-  
 22 tions (or combination thereof) to furnish benefits to the  
 23 entity’s employees, former employees (or combination  
 24 thereof) or members or former members (or combination  
 25 thereof) of the labor organizations, the Secretary may

1 waive or modify requirements that hinder the design of,  
 2 the offering of, or the enrollment in such  
 3 Medicare+Choice plans.”.

4 (b) EFFECTIVE DATE.—The amendment made by  
 5 subsection (a) shall apply with respect to years beginning  
 6 with 2001.

7 **SEC. 618. SPECIAL MEDIGAP ENROLLMENT ANTIDISCRIMI-**  
 8 **NATION PROVISION FOR CERTAIN BENE-**  
 9 **FICIARIES.**

10 (a) DISENROLLMENT WINDOW IN ACCORDANCE  
 11 WITH BENEFICIARY’S CIRCUMSTANCE.—Section  
 12 1882(s)(3) (42 U.S.C. 1395ss(s)(3)) is amended—

13 (1) in subparagraph (A), in the matter fol-  
 14 lowing clause (iii), by striking “, subject to subpara-  
 15 graph (E), seeks to enroll under the policy not later  
 16 than 63 days after the date of the termination of en-  
 17 rollment described in such subparagraph” and in-  
 18 serting “seeks to enroll under the policy during the  
 19 period specified in subparagraph (E)”; and

20 (2) by striking subparagraph (E) and inserting  
 21 the following new subparagraph:

22 “(E) For purposes of subparagraph (A), the time pe-  
 23 riod specified in this subparagraph is—

24 “(i) in the case of an individual described in  
 25 subparagraph (B)(i), the period beginning on the

1 date the individual receives a notice of termination  
2 or cessation of all supplemental health benefits (or,  
3 if no such notice is received, notice that a claim has  
4 been denied because of such a termination or ces-  
5 sation) and ending on the date that is 63 days after  
6 the applicable notice;

7 “(ii) in the case of an individual described in  
8 clause (ii), (iii), (v), or (vi) of subparagraph (B)  
9 whose enrollment is terminated involuntarily, the pe-  
10 riod beginning on the date that the individual re-  
11 ceives a notice of termination and ending on the  
12 date that is 63 days after the date the applicable  
13 coverage is terminated;

14 “(iii) in the case of an individual described in  
15 subparagraph (B)(iv)(I), the period beginning on the  
16 earlier of (I) the date that the individual receives a  
17 notice of termination, a notice of the issuer’s bank-  
18 ruptcy or insolvency, or other such similar notice, if  
19 any, and (II) the date that the applicable coverage  
20 is terminated, and ending on the date that is 63  
21 days after the date the coverage is terminated;

22 “(iv) in the case of an individual described in  
23 clause (ii), (iii), (iv)(II), (iv)(III), (v), or (vi) of sub-  
24 paragraph (B) who disenrolls voluntarily, the period  
25 beginning on the date that is 60 days before the ef-



1       fective date of the disenrollment and ending on the  
2       date that is 63 days after such effective date; and

3           “(v) in the case of an individual described in  
4       subparagraph (B) but not described in the preceding  
5       provisions of this subparagraph, the period begin-  
6       ning on the effective date of the disenrollment and  
7       ending on the date that is 63 days after such effec-  
8       tive date.”.

9       (b) EXTENDED MEDIGAP ACCESS FOR INTERRUPTED  
10   TRIAL PERIODS.—Section 1882(s)(3) (42 U.S.C.  
11 1395ss(s)(3)), as amended by subsection (a), is further  
12 amended by adding at the end the following new subpara-  
13 graph:

14       “(F)(i) Subject to clause (ii), for purposes of this  
15 paragraph—

16           “(I) in the case of an individual described in  
17       subparagraph (B)(v) (or deemed to be so described,  
18       pursuant to this subparagraph) whose enrollment  
19       with an organization or provider described in sub-  
20       clause (II) of such subparagraph is involuntarily ter-  
21       minated within the first 12 months of such enroll-  
22       ment, and who, without an intervening enrollment,  
23       enrolls with another such organization or provider,  
24       such subsequent enrollment shall be deemed to be an

1 initial enrollment described in such subparagraph;  
 2 and

3 “(II) in the case of an individual described in  
 4 clause (vi) of subparagraph (B) (or deemed to be so  
 5 described, pursuant to this subparagraph) whose en-  
 6 rollment with a plan or in a program described in  
 7 such clause is involuntarily terminated within the  
 8 first 12 months of such enrollment, and who, with-  
 9 out an intervening enrollment, enrolls in another  
 10 such plan or program, such subsequent enrollment  
 11 shall be deemed to be an initial enrollment described  
 12 in such clause.

13 “(ii) For purposes of clauses (v) and (vi) of subpara-  
 14 graph (B), no enrollment of an individual with an organi-  
 15 zation or provider described in clause (v)(II), or with a  
 16 plan or in a program described in clause (vi), may be  
 17 deemed to be an initial enrollment under this clause after  
 18 the 2-year period beginning on the date on which the indi-  
 19 vidual first enrolled with such an organization, provider,  
 20 plan, or program.”.

21 **SEC. 619. RESTORING EFFECTIVE DATE OF ELECTIONS AND**  
 22 **CHANGES OF ELECTIONS OF**  
 23 **MEDICARE+CHOICE PLANS.**

24 (a) OPEN ENROLLMENT.—Section 1851(f)(2) (42  
 25 U.S.C. 1395w–21(f)(2)) is amended by striking “, except

1 that if such election or change is made after the 10th day  
 2 of any calendar month, then the election or change shall  
 3 not take effect until the first day of the second calendar  
 4 month following the date on which the election or change  
 5 is made”.

6 (b) EFFECTIVE DATE.—The amendment made by  
 7 this section shall apply to elections and changes of cov-  
 8 erage made on or after June 1, 2001.

9 **SEC. 620. PERMITTING ESRD BENEFICIARIES TO ENROLL**  
 10 **IN ANOTHER MEDICARE+CHOICE PLAN IF**  
 11 **THE PLAN IN WHICH THEY ARE ENROLLED IS**  
 12 **TERMINATED.**

13 (a) IN GENERAL.—Section 1851(a)(3)(B) (42 U.S.C.  
 14 1395w-21(a)(3)(B)) is amended by striking “except that”  
 15 and all that follows and inserting the following: “except  
 16 that—

17 “(i) an individual who develops end-  
 18 stage renal disease while enrolled in a  
 19 Medicare+Choice plan may continue to be  
 20 enrolled in that plan; and

21 “(ii) in the case of such an individual  
 22 who is enrolled in a Medicare+Choice plan  
 23 under clause (i) (or subsequently under  
 24 this clause), if the enrollment is discon-  
 25 tinued under circumstances described in

1           section 1851(e)(4)(A), then the individual  
2           will be treated as a ‘Medicare+Choice eli-  
3           gible individual’ for purposes of electing to  
4           continue enrollment in another  
5           Medicare+Choice plan.”.

6       (b) EFFECTIVE DATE.—

7           (1) IN GENERAL.—The amendment made by  
8       subsection (a) shall apply to terminations and  
9       discontinuations occurring on or after the date of  
10      the enactment of this Act.

11       (2) APPLICATION TO PRIOR PLAN TERMI-  
12      NATIONS.—Clause (ii) of section 1851(a)(3)(B) of  
13      the Social Security Act (as inserted by subsection  
14      (a)) shall also apply to individuals whose enrollment  
15      in a Medicare+Choice plan was terminated or dis-  
16      continued after December 31, 1998, and before the  
17      date of the enactment of this Act. In applying this  
18      paragraph, such an individual shall be treated, for  
19      purposes of part C of title XVIII of the Social Secu-  
20      rity Act, as having discontinued enrollment in such  
21      a plan as of the date of the enactment of this Act.

1 **SEC. 621. PROVIDING CHOICE FOR SKILLED NURSING FA-**  
2 **CILITY SERVICES UNDER THE**  
3 **MEDICARE+CHOICE PROGRAM.**

4 (a) IN GENERAL.—Section 1852 (42 U.S.C. 1395w–  
5 22) is amended by adding at the end the following new  
6 subsection:

7 “(1) RETURN TO HOME SKILLED NURSING FACILI-  
8 TIES FOR COVERED POST-HOSPITAL EXTENDED CARE  
9 SERVICES.—

10 “(1) ENSURING RETURN TO HOME SNF.—

11 “(A) IN GENERAL.—In providing coverage  
12 of post-hospital extended care services, a  
13 Medicare+Choice plan shall provide for such  
14 coverage through a home skilled nursing facility  
15 if the following conditions are met:

16 “(i) ENROLLEE ELECTION.—The en-  
17 rollee elects to receive such coverage  
18 through such facility.

19 “(ii) SNF AGREEMENT.—The facility  
20 has a contract with the Medicare+Choice  
21 organization for the provision of such serv-  
22 ices, or the facility agrees to accept sub-  
23 stantially similar payment under the same  
24 terms and conditions that apply to simi-  
25 larly situated skilled nursing facilities that  
26 are under contract with the

1 Medicare+Choice organization for the pro-  
2 vision of such services and through which  
3 the enrollee would otherwise receive such  
4 services.

5 “(B) MANNER OF PAYMENT TO HOME  
6 SNF.—The organization shall provide payment  
7 to the home skilled nursing facility consistent  
8 with the contract or the agreement described in  
9 subparagraph (A)(ii), as the case may be.

10 “(2) NO LESS FAVORABLE COVERAGE.—The  
11 coverage provided under paragraph (1) (including  
12 scope of services, cost-sharing, and other criteria of  
13 coverage) shall be no less favorable to the enrollee  
14 than the coverage that would be provided to the en-  
15 rollee with respect to a skilled nursing facility the  
16 post-hospital extended care services of which are  
17 otherwise covered under the Medicare+Choice plan.

18 “(3) RULE OF CONSTRUCTION.—Nothing in  
19 this subsection shall be construed to do the fol-  
20 lowing:

21 “(A) To require coverage through a skilled  
22 nursing facility that is not otherwise qualified  
23 to provide benefits under part A for medicare  
24 beneficiaries not enrolled in a Medicare+Choice  
25 plan.

1           “(B) To prevent a skilled nursing facility  
2           from refusing to accept, or imposing conditions  
3           upon the acceptance of, an enrollee for the re-  
4           ceipt of post-hospital extended care services.

5           “(4) DEFINITIONS.—In this subsection:

6           “(A) HOME SKILLED NURSING FACIL-  
7           ITY.—The term ‘home skilled nursing facility’  
8           means, with respect to an enrollee who is enti-  
9           tled to receive post-hospital extended care serv-  
10          ices under a Medicare+Choice plan, any of the  
11          following skilled nursing facilities:

12           “(i) SNF RESIDENCE AT TIME OF AD-  
13          MISSION.—The skilled nursing facility in  
14          which the enrollee resided at the time of  
15          admission to the hospital preceding the re-  
16          ceipt of such post-hospital extended care  
17          services.

18           “(ii) SNF IN CONTINUING CARE RE-  
19          TIREMENT COMMUNITY.—A skilled nursing  
20          facility that is providing such services  
21          through a continuing care retirement com-  
22          munity (as defined in subparagraph (B))  
23          which provided residence to the enrollee at  
24          the time of such admission.

1 “(iii) SNF RESIDENCE OF SPOUSE AT  
2 TIME OF DISCHARGE.—The skilled nursing  
3 facility in which the spouse of the enrollee  
4 is residing at the time of discharge from  
5 such hospital.

6 “(B) CONTINUING CARE RETIREMENT  
7 COMMUNITY.—The term ‘continuing care retire-  
8 ment community’ means, with respect to an en-  
9 rollee in a Medicare+Choice plan, an arrange-  
10 ment under which housing and health-related  
11 services are provided (or arranged) through an  
12 organization for the enrollee under an agree-  
13 ment that is effective for the life of the enrollee  
14 or for a specified period.”.

15 (b) EFFECTIVE DATE.—The amendment made by  
16 subsection (a) shall apply with respect to contracts entered  
17 into or renewed on or after the date of the enactment of  
18 this Act.

19 (c) MEDPAC STUDY.—

20 (1) STUDY.—The Medicare Payment Advisory  
21 Commission shall conduct a study analyzing the ef-  
22 fects of the amendment made by subsection (a) on  
23 Medicare+Choice organizations. In conducting such  
24 study, the Commission shall examine the effects (if  
25 any) such amendment has had—



1 (A) on the scope of additional benefits pro-  
 2 vided under the Medicare+Choice program;

3 (B) on the administrative and other costs  
 4 incurred by Medicare+Choice organizations;  
 5 and

6 (C) on the contractual relationships be-  
 7 tween such organizations and skilled nursing fa-  
 8 cilities.

9 (2) REPORT.—Not later than 2 years after the  
 10 date of the enactment of this Act, the Commission  
 11 shall submit to Congress a report on the study con-  
 12 ducted under paragraph (1).

13 **SEC. 622. PROVIDING FOR ACCOUNTABILITY OF**  
 14 **MEDICARE+CHOICE PLANS.**

15 (a) MANDATORY REVIEW OF ACR SUBMISSIONS BY  
 16 THE CHIEF ACTUARY OF THE HEALTH CARE FINANCING  
 17 ADMINISTRATION.—Section 1854(a)(5)(A) (42 U.S.C.  
 18 1395w-24(a)(5)(A)) is amended—

19 (1) by striking “value” and inserting “values”;  
 20 and

21 (2) by adding at the end the following: “The  
 22 Chief Actuary of the Health Care Financing Admin-  
 23 istration shall review the actuarial assumptions and  
 24 data used by the Medicare+Choice organization with  
 25 respect to such rates, amounts, and values so sub-

1       mitted to determine the appropriateness of such as-  
2       sumptions and data.”.

3       (b) EFFECTIVE DATE.—The amendments made by  
4       subsection (a) shall apply to submissions made on or after  
5       May 1, 2001.

6       **SEC. 623. INCREASED CIVIL MONEY PENALTY FOR**  
7                   **MEDICARE+CHOICE ORGANIZATIONS THAT**  
8                   **TERMINATE CONTRACTS MID-YEAR.**

9       (a) IN GENERAL.—Section 1857(g)(3) (42 U.S.C.  
10      1395w–27(g)(3)) is amended by adding at the end the fol-  
11      lowing new subparagraph:

12                   “(D) Civil monetary penalties of not more  
13                   than \$100,000, or such higher amount as the  
14                   Secretary may establish by regulation, where  
15                   the finding under subsection (c)(2)(A) is based  
16                   on the organization’s termination of its contract  
17                   under this section other than at a time and in  
18                   a manner provided for under subsection (a).”.

19      (b) EFFECTIVE DATE.—The amendment made by  
20      subsection (a) shall apply to terminations occurring after  
21      the date of the enactment of this Act.

1     **Subtitle C—Other Managed Care**  
2                     **Reforms**

3     **SEC. 631. ONE-YEAR EXTENSION OF SOCIAL HEALTH MAIN-**  
4                     **TENANCE ORGANIZATION (SHMO) DEM-**  
5                     **ONSTRATION PROJECT.**

6             Section 4018(b)(1) of the Omnibus Budget Reconcili-  
7     ation Act of 1987, as amended by section 531(a)(1) of  
8     BBRA (113 Stat. 1501A–388), is amended by striking  
9     “18 months” and inserting “30 months”.

10    **SEC. 632. REVISED TERMS AND CONDITIONS FOR EXTEN-**  
11                    **SION OF MEDICARE COMMUNITY NURSING**  
12                    **ORGANIZATION (CNO) DEMONSTRATION**  
13                    **PROJECT.**

14             (a) IN GENERAL.—Section 532 of BBRA (113 Stat.  
15     1501A–388) is amended—

16                 (1) in subsection (a), by striking the second  
17     sentence; and

18                 (2) by striking subsection (b) and inserting the  
19     following new subsection:

20             “(b) TERMS AND CONDITIONS.—

21                 “(1) JANUARY THROUGH SEPTEMBER 2000.—

22             For the 9-month period beginning with January  
23     2000, any such demonstration project shall be con-  
24     ducted under the same terms and conditions as ap-  
25     plied to such demonstration during 1999.

1           “(2) OCTOBER 2000 THROUGH DECEMBER  
2           2001.—For the 15-month period beginning with Oc-  
3           tober 2000, any such demonstration project shall be  
4           conducted under the same terms and conditions as  
5           applied to such demonstration during 1999, except  
6           that the following modifications shall apply:

7                   “(A) BASIC CAPITATION RATE.—The basic  
8           capitation rate paid for services covered under  
9           the project (other than case management serv-  
10          ices) per enrollee per month and furnished  
11          during—

12                   “(i) the period beginning with October  
13          1, 2000, and ending with December 31,  
14          2000, shall be determined by actuarially  
15          adjusting the actual capitation rate paid  
16          for such services in 1999 for inflation, uti-  
17          lization, and other changes to the CNO  
18          service package, and by reducing such ad-  
19          justed capitation rate by 10 percent in the  
20          case of the demonstration sites located in  
21          Arizona, Minnesota, and Illinois, and 15  
22          percent for the demonstration site located  
23          in New York; and

24                   “(ii) 2001 shall be determined by ac-  
25          tuarily adjusting the capitation rate de-

1           terminated under clause (i) for inflation, uti-  
2           lization, and other changes to the CNO  
3           service package.

4           “(B)   TARGETED   CASE   MANAGEMENT  
5   FEE.—Effective October 1, 2000—

6           “(i) the case management fee per en-  
7           rollee per month for—

8                   “(I) the period described in sub-  
9                   paragraph (A)(i) shall be determined  
10                  by actuarially adjusting the case man-  
11                  agement fee for 1999 for inflation;  
12                  and

13                   “(II) 2001 shall be determined  
14                  by actuarially adjusting the amount  
15                  determined under subclause (I) for in-  
16                  flation; and

17           “(ii) such case management fee shall  
18           be paid only for enrollees who are classified  
19           as moderately frail or frail pursuant to cri-  
20           teria established by the Secretary.

21           “(C)   GREATER UNIFORMITY IN CLINICAL  
22   FEATURES AMONG SITES.—Each project shall  
23   implement for each site—

24           “(i) protocols for periodic telephonic  
25           contact with enrollees based on—

1 “(I) the results of such standard-  
2 ized written health assessment; and

3 “(II) the application of appro-  
4 priate care planning approaches;

5 “(ii) disease management programs  
6 for targeted diseases (such as congestive  
7 heart failure, arthritis, diabetes, and hy-  
8 pertension) that are highly prevalent in the  
9 enrolled populations;

10 “(iii) systems and protocols to track  
11 enrollees through hospitalizations, includ-  
12 ing pre-admission planning, concurrent  
13 management during inpatient hospital  
14 stays, and post-discharge assessment, plan-  
15 ning, and follow-up; and

16 “(iv) standardized patient educational  
17 materials for specified diseases and health  
18 conditions.

19 “(D) QUALITY IMPROVEMENT.—Each  
20 project shall implement at each site once during  
21 the 15-month period—

22 “(i) enrollee satisfaction surveys; and

23 “(ii) reporting on specified quality in-  
24 dicators for the enrolled population.

25 “(c) EVALUATION.—

1           “(1) PRELIMINARY REPORT.—Not later than  
2       July 1, 2001, the Secretary of Health and Human  
3       Services shall submit to the Committees on Ways  
4       and Means and Commerce of the House of Rep-  
5       resentatives and the Committee on Finance of the  
6       Senate a preliminary report that—

7           “(A) evaluates such demonstration projects  
8       for the period beginning July 1, 1997, and end-  
9       ing December 31, 1999, on a site-specific basis  
10      with respect to the impact on per beneficiary  
11      spending, specific health utilization measures,  
12      and enrollee satisfaction; and

13          “(B) includes a similar evaluation of such  
14      projects for the portion of the extension period  
15      that occurs after September 30, 2000.

16          “(2) FINAL REPORT.—The Secretary shall sub-  
17      mit a final report to such Committees on such dem-  
18      onstration projects not later than July 1, 2002.  
19      Such report shall include the same elements as the  
20      preliminary report required by paragraph (1), but  
21      for the period after December 31, 1999.

22          “(3) METHODOLOGY FOR SPENDING COMPARI-  
23      SONS.—Any evaluation of the impact of the dem-  
24      onstration projects on per beneficiary spending in-

1       cluded in such reports shall include a comparison  
2       of—

3               “(A) data for all individuals who—

4                       “(i) were enrolled in such demonstra-  
5                       tion projects as of the first day of the pe-  
6                       riod under evaluation; and

7                       “(ii) were enrolled for a minimum of  
8                       6 months thereafter; with

9               “(B) data for a matched sample of individ-  
10              uals who are enrolled under part B of title  
11              XVIII of the Social Security Act and are not  
12              enrolled in such a project, or in a  
13              Medicare+Choice plan under part C of such  
14              title, a plan offered by an eligible organization  
15              under section 1876 of such Act, or a health  
16              care prepayment plan under section  
17              1833(a)(1)(A) of such Act.”.

18       (b) EFFECTIVE DATE.—The amendments made by  
19       subsection (a) shall be effective as if included in the enact-  
20       ment of section 532 of BBRA (113 Stat. 1501A–388).

21       **SEC. 633. EXTENSION OF MEDICARE MUNICIPAL HEALTH**  
22               **SERVICES DEMONSTRATION PROJECTS.**

23       Section 9215(a) of the Consolidated Omnibus Budget  
24       Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as  
25       amended by section 6135 of the Omnibus Budget Rec-



1   conciliation Act of 1989, section 13557 of the Omnibus  
2   Budget Reconciliation Act of 1993, section 4017 of BBA,  
3   and section 534 of BBRA (113 Stat. 1501A–390), is  
4   amended by striking “December 31, 2002” and inserting  
5   “December 31, 2004”.

6   **SEC. 634. SERVICE AREA EXPANSION FOR MEDICARE COST**  
7                                   **CONTRACTS DURING TRANSITION PERIOD.**

8           Section 1876(h)(5) (42 U.S.C. 1395mm(h)(5)) is  
9   amended—

10                   (1) by redesignating subparagraph (B) as sub-  
11                   paragraph (C); and

12                   (2) by inserting after subparagraph (A), the fol-  
13                   lowing new subparagraph:

14           “(B) Subject to subparagraph (C), the Secretary  
15   shall approve an application for a modification to a rea-  
16   sonable cost contract under this section in order to expand  
17   the service area of such contract if—

18                   “(i) such application is submitted to the Sec-  
19                   retary on or before September 1, 2003; and

20                   “(ii) the Secretary determines that the organi-  
21                   zation with the contract continues to meet the re-  
22                   quirements applicable to such organizations and con-  
23                   tracts under this section.”.

# **TITLE VII—MEDICAID**

## **SEC. 701. DSH PAYMENTS.**

### **(a) MODIFICATIONS TO DSH ALLOTMENTS.—**

#### **(1) INCREASED ALLOTMENTS FOR FISCAL YEARS 2001 AND 2002.—**

**(A) IN GENERAL.**—Section 1923(f) (42 U.S.C. 1396r–4(f)) is amended—

(i) in paragraph (2), by striking “The DSH allotment” and inserting “Subject to paragraph (4), the DSH allotment”;

(ii) by redesignating paragraph (4) as paragraph (6); and

(iii) by inserting after paragraph (3) the following new paragraph:

“(4) SPECIAL RULE FOR FISCAL YEARS 2001 AND 2002.—

“(A) IN GENERAL.—Notwithstanding paragraph (2), the DSH allotment for any State for—

“(i) fiscal year 2001, shall be the DSH allotment determined under paragraph (2) for fiscal year 2000 increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the consumer price index for all urban con-

sumers (all items; U.S. city average) for  
fiscal year 2000; and

“(ii) fiscal year 2002, shall be the  
DSH allotment determined under clause  
(i) increased, subject to subparagraph (B)  
and paragraph (5), by the percentage  
change in the consumer price index for all  
urban consumers (all items; U.S. city aver-  
age) for fiscal year 2001.

“(B) LIMITATION.—Subparagraph (B) of  
paragraph (3) shall apply to subparagraph (A)  
of this paragraph in the same manner as that  
subparagraph (B) applies to paragraph (3)(A).

“(C) NO APPLICATION TO ALLOTMENTS  
AFTER FISCAL YEAR 2002.—The DSH allotment  
for any State for fiscal year 2003 or any suc-  
ceeding fiscal year shall be determined under  
paragraph (3) without regard to the DSH allot-  
ments determined under subparagraph (A) of  
this paragraph.”.

(2) SPECIAL RULE FOR MEDICAID DSH ALLOT-  
MENT FOR EXTREMELY LOW DSH STATES.—

(A) IN GENERAL.—Section 1923(f) (42  
U.S.C. 1396r-4(f)), as amended by paragraph

1           (1), is amended by inserting after paragraph  
2           (4) the following new paragraph:

3           “(5) SPECIAL RULE FOR EXTREMELY LOW DSH  
4           STATES.—In the case of a State in which the total  
5           expenditures under the State plan (including Federal  
6           and State shares) for disproportionate share hospital  
7           adjustments under this section for fiscal year 1999,  
8           as reported to the Administrator of the Health Care  
9           Financing Administration as of August 31, 2000, is  
10          greater than 0 but less than 1 percent of the State’s  
11          total amount of expenditures under the State plan  
12          for medical assistance during the fiscal year, the  
13          DSH allotment for fiscal year 2001 shall be in-  
14          creased to 1 percent of the State’s total amount of  
15          expenditures under such plan for such assistance  
16          during such fiscal year. In subsequent fiscal years,  
17          such increased allotment is subject to an increase for  
18          inflation as provided in paragraph (3)(A).”.

19                (B) CONFORMING AMENDMENT.—Section  
20                1923(f)(3)(A) (42 U.S.C. 1396r–4(f)(3)(A)) is  
21                amended by inserting “and paragraph (5)”  
22                after “subparagraph (B)”.

23                (3) EFFECTIVE DATE.—The amendments made  
24                by paragraphs (1) and (2) take effect on the date  
25                the final regulation required under section 705(a)

1 (relating to the application of an aggregate upper  
2 payment limit test for State medicaid spending for  
3 inpatient hospital services, outpatient hospital serv-  
4 ices, nursing facility services, intermediate care facil-  
5 ity services for the mentally retarded, and clinic  
6 services provided by government facilities that are  
7 not State-owned or operated facilities) is published  
8 in the Federal Register.

9 (b) ASSURING IDENTIFICATION OF MEDICAID MAN-  
10 AGED CARE PATIENTS.—

11 (1) IN GENERAL.—Section 1932 (42 U.S.C.  
12 1396u–2) is amended by adding at the end the fol-  
13 lowing new subsection:

14 “(g) IDENTIFICATION OF PATIENTS FOR PURPOSES  
15 OF MAKING DSH PAYMENTS.—Each contract with a  
16 managed care entity under section 1903(m) or under sec-  
17 tion 1905(t)(3) shall require the entity either—

18 “(1) to report to the State information nec-  
19 essary to determine the hospital services provided  
20 under the contract (and the identity of hospitals pro-  
21 viding such services) for purposes of applying sec-  
22 tions 1886(d)(5)(F) and 1923; or

23 “(2) to include a sponsorship code in the identi-  
24 fication card issued to individuals covered under this

1 title in order that a hospital may identify a patient  
2 as being entitled to benefits under this title.”.

3 (2) CLARIFICATION OF COUNTING MANAGED  
4 CARE MEDICAID PATIENTS.—Section 1923 (42  
5 U.S.C. 1396r–4) is amended—

6 (A) in subsection (a)(2)(D), by inserting  
7 after “the proportion of low-income and med-  
8 icaid patients” the following: “(including such  
9 patients who receive benefits through a man-  
10 aged care entity)”;

11 (B) in subsection (b)(2), by inserting after  
12 “a State plan approved under this title in a pe-  
13 riod” the following: “(regardless of whether  
14 such patients receive medical assistance on a  
15 fee-for-service basis or through a managed care  
16 entity)”;

17 (C) in subsection (b)(3)(A)(i), by inserting  
18 after “under a State plan under this title” the  
19 following: “(regardless of whether the services  
20 were furnished on a fee-for-service basis or  
21 through a managed care entity)”.

22 (3) EFFECTIVE DATES.—

23 (A) The amendment made by paragraph  
24 (1) shall apply to contracts as of January 1,  
25 2001.

1 (B) The amendments made by paragraph  
2 (2) shall apply to payments made on or after  
3 January 1, 2001.

4 (c) APPLICATION OF MEDICAID DSH TRANSITION  
5 RULE TO PUBLIC HOSPITALS IN ALL STATES.—

6 (1) IN GENERAL.—During the period described  
7 in paragraph (3), with respect to a State, section  
8 4721(e) of the Balanced Budget Act of 1997 (Public  
9 Law 105–33; 111 Stat. 514), as amended by section  
10 607 of BBRA (113 Stat. 1501A–396), shall be ap-  
11 plied as though—

12 (A) “September 30, 2002” were sub-  
13 stituted for “July 1, 1997” each place it ap-  
14 pears;

15 (B) “hospitals owned or operated by a  
16 State (as defined for purposes of title XIX of  
17 such Act), or by an instrumentality or a unit of  
18 government within a State (as so defined)”  
19 were substituted for “the State of California”;

20 (C) paragraph (3) were redesignated as  
21 paragraph (4);

22 (D) “and” were omitted from the end of  
23 paragraph (2); and

24 (E) the following new paragraph were in-  
25 serted after paragraph (2):

1           “(3) ‘(as defined in subparagraph (B) but with-  
2           out regard to clause (ii) of that subparagraph and  
3           subject to subsection (d))’ were substituted for ‘(as  
4           defined in subparagraph (B))’ in subparagraph (A)  
5           of such section; and”.

6           (2) SPECIAL RULE.—With respect to California,  
7           section 4721(e) of the Balanced Budget Act of 1997  
8           (Public Law 105–33; 111 Stat. 514), as so amend-  
9           ed, shall be applied without regard to paragraph (1).

10          (3) PERIOD DESCRIBED.—The period described  
11          in this paragraph is the period that begins, with re-  
12          spect to a State, on the first day of the first State  
13          fiscal year that begins after September 30, 2002,  
14          and ends on the last day of the succeeding State fis-  
15          cal year.

16          (4) APPLICATION TO WAIVERS.—With respect  
17          to a State operating under a waiver of the require-  
18          ments of title XIX of the Social Security Act (42  
19          U.S.C. 1396 et seq.) under section 1115 of such Act  
20          (42 U.S.C. 1315), the amount by which any pay-  
21          ment adjustment made by the State under title XIX  
22          of such Act (42 U.S.C. 1396 et seq.), after the ap-  
23          plication of section 4721(e) of the Balanced Budget  
24          Act of 1997 under paragraph (1) to such State, ex-  
25          ceeds the costs of furnishing hospital services pro-



1 vided by hospitals described in such section shall be  
 2 fully reflected as an increase in the baseline expendi-  
 3 ture limit for such waiver.

4 (d) ASSISTANCE FOR CERTAIN PUBLIC HOS-  
 5 PITALS.—

6 (1) IN GENERAL.—Beginning with fiscal year  
 7 2002, notwithstanding section 1923(f) of the Social  
 8 Security Act (42 U.S.C. 1396r–4(f)) and subject to  
 9 paragraph (3), with respect to a State, payment ad-  
 10 justments made under title XIX of the Social Secu-  
 11 rity Act (42 U.S.C. 1396 et seq.) to a hospital de-  
 12 scribed in paragraph (2) shall be made without re-  
 13 gard to the DSH allotment limitation for the State  
 14 determined under section 1923(f) of that Act (42  
 15 U.S.C. 1396r–4(f)).

16 (2) HOSPITAL DESCRIBED.—A hospital is de-  
 17 scribed in this paragraph if the hospital—

18 (A) is owned or operated by a State (as de-  
 19 fined for purposes of title XIX of the Social Se-  
 20 curity Act), or by an instrumentality or a unit  
 21 of government within a State (as so defined);

22 (B) as of October 1, 2000—

23 (i) is in existence and operating as a  
 24 hospital described in subparagraph (A);  
 25 and

1                   (ii) is not receiving disproportionate  
2                   share hospital payments from the State in  
3                   which it is located under title XIX of such  
4                   Act; and

5                   (C) has a low-income utilization rate (as  
6                   defined in section 1923(b)(3) of the Social Se-  
7                   curity Act (42 U.S.C. 1396r-4(b)(3))) in excess  
8                   of 65 percent.

9                   (3) LIMITATION ON EXPENDITURES.—

10                   (A) IN GENERAL.—With respect to any fis-  
11                   cal year, the aggregate amount of Federal fi-  
12                   nancial participation that may be provided for  
13                   payment adjustments described in paragraph  
14                   (1) for that fiscal year for all States may not  
15                   exceed the amount described in subparagraph  
16                   (B) for the fiscal year.

17                   (B) AMOUNT DESCRIBED.—The amount  
18                   described in this subparagraph for a fiscal year  
19                   is as follows:

20                   (i) For fiscal year 2002, \$15,000,000.

21                   (ii) For fiscal year 2003,  
22                   \$176,000,000.

23                   (iii) For fiscal year 2004,  
24                   \$269,000,000.

1 (iv) For fiscal year 2005,  
2 \$330,000,000.

3 (v) For fiscal year 2006 and each fis-  
4 cal year thereafter, \$375,000,000.

5 (e) DSH PAYMENT ACCOUNTABILITY STANDARDS.—

6 Not later than September 30, 2002, the Secretary of  
7 Health and Human Services shall implement account-  
8 ability standards to ensure that Federal funds provided  
9 with respect to disproportionate share hospital adjust-  
10 ments made under section 1923 of the Social Security Act  
11 (42 U.S.C. 1396r–4) are used to reimburse States and  
12 hospitals eligible for such payment adjustments for pro-  
13 viding uncompensated health care to low-income patients  
14 and are otherwise made in accordance with the require-  
15 ments of section 1923 of that Act.

16 **SEC. 702. NEW PROSPECTIVE PAYMENT SYSTEM FOR FED-**  
17 **ERALLY-QUALIFIED HEALTH CENTERS AND**  
18 **RURAL HEALTH CLINICS.**

19 (a) IN GENERAL.—Section 1902(a) (42 U.S.C.  
20 1396a(a)) is amended—

21 (1) in paragraph (13)—

22 (A) in subparagraph (A), by adding “and”  
23 at the end;

24 (B) in subparagraph (B), by striking  
25 “and” at the end; and

1 (C) by striking subparagraph (C); and

2 (2) by inserting after paragraph (14) the fol-  
3 lowing new paragraph:

4 “(15) provide for payment for services de-  
5 scribed in clause (B) or (C) of section 1905(a)(2)  
6 under the plan in accordance with subsection (aa);”.

7 (b) NEW PROSPECTIVE PAYMENT SYSTEM.—Section  
8 1902 (42 U.S.C. 1396a) is amended by adding at the end  
9 the following:

10 “(aa) PAYMENT FOR SERVICES PROVIDED BY FED-  
11 ERALLY-QUALIFIED HEALTH CENTERS AND RURAL  
12 HEALTH CLINICS.—

13 “(1) IN GENERAL.—Beginning with fiscal year  
14 2001 with respect to services furnished on or after  
15 January 1, 2001, and each succeeding fiscal year,  
16 the State plan shall provide for payment for services  
17 described in section 1905(a)(2)(C) furnished by a  
18 Federally-qualified health center and services de-  
19 scribed in section 1905(a)(2)(B) furnished by a  
20 rural health clinic in accordance with the provisions  
21 of this subsection.

22 “(2) FISCAL YEAR 2001.—Subject to paragraph  
23 (4), for services furnished on and after January 1,  
24 2001, during fiscal year 2001, the State plan shall  
25 provide for payment for such services in an amount

1 (calculated on a per visit basis) that is equal to 100  
2 percent of the average of the costs of the center or  
3 clinic of furnishing such services during fiscal years  
4 1999 and 2000 which are reasonable and related to  
5 the cost of furnishing such services, or based on  
6 such other tests of reasonableness as the Secretary  
7 prescribes in regulations under section 1833(a)(3),  
8 or, in the case of services to which such regulations  
9 do not apply, the same methodology used under sec-  
10 tion 1833(a)(3), adjusted to take into account any  
11 increase or decrease in the scope of such services  
12 furnished by the center or clinic during fiscal year  
13 2001.

14 “(3) FISCAL YEAR 2002 AND SUCCEEDING FIS-  
15 CAL YEARS.—Subject to paragraph (4), for services  
16 furnished during fiscal year 2002 or a succeeding  
17 fiscal year, the State plan shall provide for payment  
18 for such services in an amount (calculated on a per  
19 visit basis) that is equal to the amount calculated for  
20 such services under this subsection for the preceding  
21 fiscal year—

22 “(A) increased by the percentage increase  
23 in the MEI (as defined in section 1842(i)(3))  
24 applicable to primary care services (as defined  
25 in section 1842(i)(4)) for that fiscal year; and

1           “(B) adjusted to take into account any in-  
2           crease or decrease in the scope of such services  
3           furnished by the center or clinic during that fis-  
4           cal year.

5           “(4) ESTABLISHMENT OF INITIAL YEAR PAY-  
6           MENT AMOUNT FOR NEW CENTERS OR CLINICS.—In  
7           any case in which an entity first qualifies as a Fed-  
8           erally-qualified health center or rural health clinic  
9           after fiscal year 2000, the State plan shall provide  
10          for payment for services described in section  
11          1905(a)(2)(C) furnished by the center or services  
12          described in section 1905(a)(2)(B) furnished by the  
13          clinic in the first fiscal year in which the center or  
14          clinic so qualifies in an amount (calculated on a per  
15          visit basis) that is equal to 100 percent of the costs  
16          of furnishing such services during such fiscal year  
17          based on the rates established under this subsection  
18          for the fiscal year for other such centers or clinics  
19          located in the same or adjacent area with a similar  
20          case load or, in the absence of such a center or clin-  
21          ic, in accordance with the regulations and method-  
22          ology referred to in paragraph (2) or based on such  
23          other tests of reasonableness as the Secretary may  
24          specify. For each fiscal year following the fiscal year  
25          in which the entity first qualifies as a Federally-

1 qualified health center or rural health clinic, the  
2 State plan shall provide for the payment amount to  
3 be calculated in accordance with paragraph (3).

4 “(5) ADMINISTRATION IN THE CASE OF MAN-  
5 AGED CARE.—

6 “(A) IN GENERAL.—In the case of services  
7 furnished by a Federally-qualified health center  
8 or rural health clinic pursuant to a contract be-  
9 tween the center or clinic and a managed care  
10 entity (as defined in section 1932(a)(1)(B)), the  
11 State plan shall provide for payment to the cen-  
12 ter or clinic by the State of a supplemental pay-  
13 ment equal to the amount (if any) by which the  
14 amount determined under paragraphs (2), (3),  
15 and (4) of this subsection exceeds the amount  
16 of the payments provided under the contract.

17 “(B) PAYMENT SCHEDULE.—The supple-  
18 mental payment required under subparagraph  
19 (A) shall be made pursuant to a payment  
20 schedule agreed to by the State and the Feder-  
21 ally-qualified health center or rural health clin-  
22 ic, but in no case less frequently than every 4  
23 months.

24 “(6) ALTERNATIVE PAYMENT METHODOLO-  
25 GIES.—Notwithstanding any other provision of this

1 section, the State plan may provide for payment in  
 2 any fiscal year to a Federally-qualified health center  
 3 for services described in section 1905(a)(2)(C) or to  
 4 a rural health clinic for services described in section  
 5 1905(a)(2)(B) in an amount which is determined  
 6 under an alternative payment methodology that—

7 “(A) is agreed to by the State and the cen-  
 8 ter or clinic; and

9 “(B) results in payment to the center or  
 10 clinic of an amount which is at least equal to  
 11 the amount otherwise required to be paid to the  
 12 center or clinic under this section.”.

13 (c) CONFORMING AMENDMENTS.—

14 (1) Section 4712 of the BBA (Public Law 105–  
 15 33; 111 Stat. 508) is amended by striking sub-  
 16 section (c).

17 (2) Section 1915(b) (42 U.S.C. 1396n(b)) is  
 18 amended by striking “1902(a)(13)(C)” and inserting  
 19 “1902(a)(15), 1902(aa),”.

20 (d) GAO STUDY OF FUTURE REBASING.—The  
 21 Comptroller General of the United States shall provide for  
 22 a study on the need for, and how to, rebase or refine costs  
 23 for making payment under the medicaid program for serv-  
 24 ices provided by Federally-qualified health centers and  
 25 rural health clinics (as provided under the amendments



1 made by this section). The Comptroller General shall pro-  
2 vide for submittal of a report on such study to Congress  
3 by not later than 4 years after the date of the enactment  
4 of this Act.

5 (e) EFFECTIVE DATE.—The amendments made by  
6 this section take effect on January 1, 2001, and shall  
7 apply to services furnished on or after such date.

8 **SEC. 703. STREAMLINED APPROVAL OF CONTINUED STATE-**  
9 **WIDE SECTION 1115 MEDICAID WAIVERS.**

10 (a) IN GENERAL.—Section 1115 (42 U.S.C. 1315)  
11 is amended by adding at the end the following new sub-  
12 section:

13 “(f) An application by the chief executive officer of  
14 a State for an extension of a waiver project the State is  
15 operating under an extension under subsection (e) (in this  
16 subsection referred to as the ‘waiver project’) shall be sub-  
17 mitted and approved or disapproved in accordance with  
18 the following:

19 “(1) The application for an extension of the  
20 waiver project shall be submitted to the Secretary at  
21 least 120 days prior to the expiration of the current  
22 period of the waiver project.

23 “(2) Not later than 45 days after the date such  
24 application is received by the Secretary, the Sec-  
25 retary shall notify the State if the Secretary intends

1 to review the terms and conditions of the waiver  
2 project. A failure to provide such notification shall  
3 be deemed to be an approval of the application.

4 “(3) Not later than 45 days after the date a no-  
5 tification is made in accordance with paragraph (2),  
6 the Secretary shall inform the State of proposed  
7 changes in the terms and conditions of the waiver  
8 project. A failure to provide such information shall  
9 be deemed to be an approval of the application.

10 “(4) During the 30-day period that begins on  
11 the date information described in paragraph (3) is  
12 provided to a State, the Secretary shall negotiate re-  
13 vised terms and conditions of the waiver project with  
14 the State.

15 “(5)(A) Not later than 120 days after the date  
16 an application for an extension of the waiver project  
17 is submitted to the Secretary (or such later date  
18 agreed to by the chief executive officer of the State),  
19 the Secretary shall—

20 “(i) approve the application subject to such  
21 modifications in the terms and conditions—

22 “(I) as have been agreed to by the  
23 Secretary and the State; or

24 “(II) in the absence of such agree-  
25 ment, as are determined by the Secretary

1 to be reasonable, consistent with the over-  
2 all objectives of the waiver project, and not  
3 in violation of applicable law; or  
4 “(ii) disapprove the application.

5 “(B) A failure by the Secretary to approve or  
6 disapprove an application submitted under this sub-  
7 section in accordance with the requirements of sub-  
8 paragraph (A) shall be deemed to be an approval of  
9 the application subject to such modifications in the  
10 terms and conditions as have been agreed to (if any)  
11 by the Secretary and the State.

12 “(6) An approval of an application for an exten-  
13 sion of a waiver project under this subsection shall  
14 be for a period not to exceed 3 years.

15 “(7) An extension of a waiver project under this  
16 subsection shall be subject to the final reporting and  
17 evaluation requirements of paragraphs (4) and (5)  
18 of subsection (e) (taking into account the extension  
19 under this subsection with respect to any timing re-  
20 quirements imposed under those paragraphs).”.

21 (b) EFFECTIVE DATE.—The amendment made by  
22 subsection (a) shall apply to requests for extensions of  
23 demonstration projects pending or submitted on or after  
24 the date of the enactment of this Act.

1 **SEC. 704. MEDICAID COUNTY-ORGANIZED HEALTH SYS-**  
2 **TEMS.**

3 (a) IN GENERAL.—Section 9517(c)(3)(C) of the  
4 Comprehensive Omnibus Budget Reconciliation Act of  
5 1985 is amended by striking “10 percent” and inserting  
6 “14 percent”.

7 (b) EFFECTIVE DATE.—The amendment made by  
8 subsection (a) takes effect on the date of the enactment  
9 of this Act.

10 **SEC. 705. DEADLINE FOR ISSUANCE OF FINAL REGULATION**  
11 **RELATING TO MEDICAID UPPER PAYMENT**  
12 **LIMITS.**

13 (a) IN GENERAL.—Not later than December 31,  
14 2000, the Secretary of Health and Human Services (in  
15 this section referred to as the “Secretary”), notwith-  
16 standing any requirement of the Administrative Proce-  
17 dures Act under chapter 5 of title 5, United States Code,  
18 or any other provision of law, shall issue under sections  
19 447.272, 447.304, and 447.321 of title 42, Code of Fed-  
20 eral Regulations (and any other section of part 447 of title  
21 42, Code of Federal Regulations that the Secretary deter-  
22 mines is appropriate), a final regulation based on the pro-  
23 posed rule announced on October 5, 2000, that—

24 (1) modifies the upper payment limit test ap-  
25 plied to State medicaid spending for inpatient hos-  
26 pital services, outpatient hospital services, nursing

1 facility services, intermediate care facility services  
2 for the mentally retarded, and clinic services by ap-  
3 plying an aggregate upper payment limit to pay-  
4 ments made to government facilities that are not  
5 State-owned or operated facilities; and

6 (2) provides for a transition period in accord-  
7 ance with subsection (b).

8 (b) TRANSITION PERIOD.—

9 (1) IN GENERAL.—The final regulation required  
10 under subsection (a) shall provide that, with respect  
11 to a State described in paragraph (3), the State  
12 shall be considered to be in compliance with the final  
13 regulation required under subsection (a) so long as,  
14 for each State fiscal year during the period de-  
15 scribed in paragraph (4), the State reduces pay-  
16 ments under a State medicaid plan payment provi-  
17 sion or methodology described in paragraph (3) (in-  
18 cluding a payment provision or methodology de-  
19 scribed in that paragraph that was approved under  
20 a waiver of such plan), or reduces the actual dollar  
21 payment levels described in paragraph (3)(B), so  
22 that the amount of the payments that would other-  
23 wise have been made under such provision, method-  
24 ology, or payment levels by the State for any State  
25 fiscal year during such period is reduced by 15 per-

1 cent in the first such State fiscal year, and by an  
2 additional 15 percent in each of the next 5 State fis-  
3 cal years.

4 (2) REQUIREMENT.—Notwithstanding para-  
5 graph (1), the final regulation required under sub-  
6 section (a) shall provide that, for any period (or por-  
7 tion of a period) that occurs on or after October 1,  
8 2008, medicaid payments made by a State described  
9 in paragraph (3) shall comply with such final regula-  
10 tion.

11 (3) STATE DESCRIBED.—A State described in  
12 this paragraph is a State with a State medicaid plan  
13 payment provision or methodology (including a pay-  
14 ment provision or methodology approved under a  
15 waiver of such plan) which—

16 (A) was approved, deemed to have been ap-  
17 proved, or was in effect on or before October 1,  
18 1992 (including any subsequent amendments or  
19 successor provisions or methodologies and  
20 whether or not a State plan amendment was  
21 made to carry out such provision or method-  
22 ology after such date) or under which claims for  
23 Federal financial participation were filed and  
24 paid on or before such date; and

1 (B) provides for payments that are in ex-  
2 cess of the upper payment limit test established  
3 under the final regulation required under sub-  
4 section (a) (or which would be noncompliant  
5 with such final regulation if the actual dollar  
6 payment levels made under the payment provi-  
7 sion or methodology in the State fiscal year  
8 which begins during 1999 were continued).

9 (4) PERIOD DESCRIBED.—The period described  
10 in this paragraph is the period that begins on the  
11 first State fiscal year that begins after September  
12 30, 2002, and ends on September 30, 2008.

13 **SEC. 706. ALASKA FMAP.**

14 Notwithstanding the first sentence of section 1905(b)  
15 of the Social Security Act (42 U.S.C. 1396d(b)), only with  
16 respect to each of fiscal years 2001 through 2005, for pur-  
17 poses of titles XIX and XXI of the Social Security Act,  
18 the State percentage used to determine the Federal med-  
19 ical assistance percentage for Alaska shall be that percent-  
20 age which bears the same ratio to 45 percent as the square  
21 of the adjusted per capita income of Alaska (determined  
22 by dividing the State's 3-year average per capita income  
23 by 1.05) bears to the square of the per capita income of  
24 the 50 States.

1 **SEC. 707. ONE-YEAR EXTENSION OF WELFARE-TO-WORK**  
2 **TRANSITION.**

3 (a) IN GENERAL.—Section 1925(f) (42 U.S.C.  
4 1396r–6(f)) is amended by striking “2001” and inserting  
5 “2002”.

6 (b) CONFORMING AMENDMENT.—Section  
7 1902(e)(1)(B) (42 U.S.C. 1396a(e)(1)(B)) is amended by  
8 striking “2001” and inserting “2002”.

9 **SEC. 708. ADDITIONAL ENTITIES QUALIFIED TO DETER-**  
10 **MINE MEDICAID PRESUMPTIVE ELIGIBILITY**  
11 **FOR LOW-INCOME CHILDREN.**

12 (a) IN GENERAL.—Section 1920A(b)(3)(A)(i) (42  
13 U.S.C. 1396r–1a(b)(3)(A)(i)) is amended—

14 (1) by striking “or (II)” and inserting “, (II)”;  
15 and

16 (2) by inserting “eligibility of a child for med-  
17 ical assistance under the State plan under this title,  
18 or eligibility of a child for child health assistance  
19 under the program funded under title XXI, (III) is  
20 an elementary school or secondary school, as such  
21 terms are defined in section 14101 of the Elemen-  
22 tary and Secondary Education Act of 1965 (20  
23 U.S.C. 8801), an elementary or secondary school op-  
24 erated or supported by the Bureau of Indian Affairs,  
25 a State or tribal child support enforcement agency,  
26 an organization that is providing emergency food



1 and shelter under a grant under the Stewart B.  
2 McKinney Homeless Assistance Act, or a State or  
3 tribal office or entity involved in enrollment in the  
4 program under this title, under part A of title IV,  
5 under title XXI, or that determines eligibility for  
6 any assistance or benefits provided under any pro-  
7 gram of public or assisted housing that receives Fed-  
8 eral funds, including the program under section 8 or  
9 any other section of the United States Housing Act  
10 of 1937 (42 U.S.C. 1437 et seq.) or under the Na-  
11 tive American Housing Assistance and Self-Deter-  
12 mination Act of 1996 (25 U.S.C. 4101 et seq.), or  
13 (IV) any other entity the State so deems, as ap-  
14 proved by the Secretary” before the semicolon.

15 (b) TECHNICAL AMENDMENTS.—Section 1920A (42  
16 U.S.C. 1396r–1a) is amended—

17 (1) in subsection (b)(3)(A)(i), by striking “42  
18 U.S.C. 9821” and inserting “42 U.S.C. 9831”;

19 (2) in subsection (b)(3)(A)(ii), by striking  
20 “paragraph (1)(A)” and inserting “paragraph (2)”;  
21 and

22 (3) in subsection (c)(2), in the matter preceding  
23 subparagraph (A), by striking “subsection  
24 (b)(1)(A)” and inserting “subsection (b)(2)”.

1 **SEC. 709. DEVELOPMENT OF UNIFORM QMB/SLMB APPLICA-**  
2 **TION FORM.**

3 (a) IN GENERAL.—Section 1905(p) (42 U.S.C.  
4 1396d(p)) is amended by adding at the end the following  
5 new paragraph:

6 “(5)(A) The Secretary shall develop and distribute to  
7 States a simplified application form for use by individuals  
8 (including both qualified medicare beneficiaries and speci-  
9 fied low-income medicare beneficiaries) in applying for  
10 medical assistance for medicare cost-sharing under this  
11 title in the States which elect to use such form. Such form  
12 shall be easily readable by applicants and uniform nation-  
13 ally.

14 “(B) In developing such form, the Secretary shall  
15 consult with beneficiary groups and the States.”.

16 (b) EFFECTIVE DATE.—The amendment made by  
17 subsection (a) shall take effect 1 year after the date of  
18 the enactment of this Act, regardless of whether regula-  
19 tions have been promulgated to carry out such amendment  
20 by such date. The Secretary of Health and Human Serv-  
21 ices shall develop the uniform application form under such  
22 amendment by not later than 9 months after the date of  
23 the enactment of this Act.

24 **SEC. 710. TECHNICAL CORRECTIONS.**

25 (a) IN GENERAL.—Section 1903(f)(4) (42 U.S.C.  
26 1396b(f)(4)) is amended—

1 (1) by inserting “1902(a)(10)(A)(ii)(XVII),”  
 2 after “1902(a)(10)(A)(ii)(XVI),”; and

3 (2) by inserting “1902(a)(10)(A)(ii)(XVIII),”  
 4 after “1902(a)(10)(A)(ii)(XVII),”.

5 (b) EFFECTIVE DATES.—(1) The amendment made  
 6 by subsection (a)(1) shall be effective as if included in the  
 7 enactment of section 121 of the Foster Care Independence  
 8 Act of 1999 (Public Law 106–169).

9 (2) The amendment made by subsection (a)(2) shall  
 10 be effective as if included in the enactment of the Breast  
 11 and Cervical Cancer Prevention and Treatment Act of  
 12 2000 (Public Law 106–354).

## 13 **TITLE VIII—STATE CHILDREN’S** 14 **HEALTH INSURANCE PROGRAM**

### 15 **SEC. 801. SPECIAL RULE FOR REDISTRIBUTION AND AVAIL-** 16 **ABILITY OF UNUSED FISCAL YEAR 1998 AND** 17 **1999 SCHIP ALLOTMENTS.**

18 (a) CHANGE IN RULES FOR REDISTRIBUTION AND  
 19 RETENTION OF UNUSED SCHIP ALLOTMENTS FOR FIS-  
 20 CAL YEARS 1998 AND 1999.—Section 2104 (42 U.S.C.  
 21 1397dd) is amended by adding at the end the following  
 22 new subsection:

23 “(g) RULE FOR REDISTRIBUTION AND EXTENDED  
 24 AVAILABILITY OF FISCAL YEARS 1998 AND 1999 ALLOT-  
 25 MENTS.—

1 “(1) AMOUNT REDISTRIBUTED.—

2 “(A) IN GENERAL.—In the case of a State  
3 that expends all of its allotment under sub-  
4 section (b) or (c) for fiscal year 1998 by the  
5 end of fiscal year 2000, or for fiscal year 1999  
6 by the end of fiscal year 2001, the Secretary  
7 shall redistribute to the State under subsection  
8 (f) (from the fiscal year 1998 or 1999 allot-  
9 ments of other States, respectively, as deter-  
10 mined by the application of paragraphs (2) and  
11 (3) with respect to the respective fiscal year)  
12 the following amount:

13 “(i) STATE.—In the case of one of the  
14 50 States or the District of Columbia, with  
15 respect to—

16 “(I) the fiscal year 1998 allot-  
17 ment, the amount by which the  
18 State’s expenditures under this title in  
19 fiscal years 1998, 1999, and 2000 ex-  
20 ceed the State’s allotment for fiscal  
21 year 1998 under subsection (b); or

22 “(II) the fiscal year 1999 allot-  
23 ment, the amount by which the  
24 State’s expenditures under this title in  
25 fiscal years 1999, 2000, and 2001 ex-

1           ceed the State's allotment for fiscal  
2           year 1999 under subsection (b).

3           “(ii) TERRITORY.—In the case of a  
4           commonwealth or territory described in  
5           subsection (c)(3), an amount that bears  
6           the same ratio to 1.05 percent of the total  
7           amount described in paragraph (2)(B)(i)(I)  
8           as the ratio of the commonwealth's or ter-  
9           ritory's fiscal year 1998 or 1999 allotment  
10          under subsection (c) (as the case may be)  
11          bears to the total of all such allotments for  
12          such fiscal year under such subsection.

13          “(B) EXPENDITURE RULES.—An amount  
14          redistributed to a State under this paragraph  
15          with respect to fiscal year 1998 or 1999—

16               “(i) shall not be included in the deter-  
17               mination of the State's allotment for any  
18               fiscal year under this section;

19               “(ii) notwithstanding subsection (e),  
20               shall remain available for expenditure by  
21               the State through the end of fiscal year  
22               2002; and

23               “(iii) shall be counted as being ex-  
24               pended with respect to a fiscal year allot-

1                   ment in accordance with applicable regula-  
2                   tions of the Secretary.

3                   “(2) EXTENSION OF AVAILABILITY OF PORTION  
4                   OF UNEXPENDED FISCAL YEARS 1998 AND 1999 AL-  
5                   LOTMENTS.—

6                   “(A) IN GENERAL.—Notwithstanding sub-  
7                   section (e):

8                   “(i) FISCAL YEAR 1998 ALLOTMENT.—  
9                   Of the amounts allotted to a State pursu-  
10                  ant to this section for fiscal year 1998 that  
11                  were not expended by the State by the end  
12                  of fiscal year 2000, the amount specified in  
13                  subparagraph (B) for fiscal year 1998 for  
14                  such State shall remain available for ex-  
15                  penditure by the State through the end of  
16                  fiscal year 2002.

17                  “(ii) FISCAL YEAR 1999 ALLOT-  
18                  MENT.—Of the amounts allotted to a State  
19                  pursuant to this subsection for fiscal year  
20                  1999 that were not expended by the State  
21                  by the end of fiscal year 2001, the amount  
22                  specified in subparagraph (B) for fiscal  
23                  year 1999 for such State shall remain  
24                  available for expenditure by the State  
25                  through the end of fiscal year 2002.

“(B) AMOUNT REMAINING AVAILABLE FOR EXPENDITURE.—The amount specified in this subparagraph for a State for a fiscal year is equal to—

“(i) the amount by which (I) the total amount available for redistribution under subsection (f) from the allotments for that fiscal year, exceeds (II) the total amounts redistributed under paragraph (1) for that fiscal year; multiplied by

“(ii) the ratio of the amount of such State’s unexpended allotment for that fiscal year to the total amount described in clause (i)(I) for that fiscal year.

“(C) USE OF UP TO 10 PERCENT OF RETAINED 1998 ALLOTMENTS FOR OUTREACH ACTIVITIES.—Notwithstanding section 2105(c)(2)(A), with respect to any State described in subparagraph (A)(i), the State may use up to 10 percent of the amount specified in subparagraph (B) for fiscal year 1998 for expenditures for outreach activities approved by the Secretary.

“(3) DETERMINATION OF AMOUNTS.—For purposes of calculating the amounts described in para-

1 graphs (1) and (2) relating to the allotment for fis-  
 2 cal year 1998 or fiscal year 1999, the Secretary  
 3 shall use the amounts reported by the States not  
 4 later than December 15, 2000, or November 30,  
 5 2001, respectively, on HCFA Form 64 or HCFA  
 6 Form 21, as approved by the Secretary.”.

7 (b) EFFECTIVE DATE.—The amendments made by  
 8 this section shall take effect as if included in the enact-  
 9 ment of section 4901 of BBA (111 Stat. 552).

10 **SEC. 802. AUTHORITY TO PAY MEDICAID EXPANSION SCHIP**  
 11 **COSTS FROM TITLE XXI APPROPRIATION.**

12 (a) AUTHORITY TO PAY MEDICAID EXPANSION  
 13 SCHIP COSTS FROM TITLE XXI APPROPRIATION.—Sec-  
 14 tion 2105(a) (42 U.S.C. 1397ee(a)) is amended—

15 (1) by redesignating subparagraphs (A) through  
 16 (D) of paragraph (2) as clauses (i) through (iv), re-  
 17 spectively, and indenting appropriately;

18 (2) by redesignating paragraph (1) as subpara-  
 19 graph (C), and indenting appropriately;

20 (3) by redesignating paragraph (2) as subpara-  
 21 graph (D), and indenting appropriately;

22 (4) by striking “(a) IN GENERAL.—” and the  
 23 remainder of the text that precedes subparagraph  
 24 (C), as so redesignated, and inserting the following:

25 “(a) PAYMENTS.—



1           “(1) IN GENERAL.—Subject to the succeeding  
2       provisions of this section, the Secretary shall pay to  
3       each State with a plan approved under this title,  
4       from its allotment under section 2104, an amount  
5       for each quarter equal to the enhanced FMAP (or,  
6       in the case of expenditures described in subpara-  
7       graph (B), the Federal medical assistance percent-  
8       age (as defined in the first sentence of section  
9       1905(b))) of expenditures in the quarter—

10           “(A) for child health assistance under the  
11       plan for targeted low-income children in the  
12       form of providing medical assistance for which  
13       payment is made on the basis of an enhanced  
14       FMAP under the fourth sentence of section  
15       1905(b);

16           “(B) for the provision of medical assist-  
17       ance on behalf of a child during a presumptive  
18       eligibility period under section 1920A;”;

19       (5) by adding after subparagraph (D), as so re-  
20       designated, the following new paragraph:

21           “(2) ORDER OF PAYMENTS.—Payments under  
22       paragraph (1) from a State’s allotment shall be  
23       made in the following order:

24           “(A) First, for expenditures for items de-  
25       scribed in paragraph (1)(A).

1                   “(B) Second, for expenditures for items  
2                   described in paragraph (1)(B).

3                   “(C) Third, for expenditures for items de-  
4                   scribed in paragraph (1)(C).

5                   “(D) Fourth, for expenditures for items  
6                   described in paragraph (1)(D).”.

7           (b) ELIMINATION OF REQUIREMENT TO REDUCE  
8 TITLE XXI ALLOTMENT BY MEDICAID EXPANSION  
9 SCHIP COSTS.—Section 2104 (42 U.S.C. 1397dd) is  
10 amended by striking subsection (d).

11           (c) AUTHORITY TO TRANSFER TITLE XXI APPRO-  
12 PRIATIONS TO TITLE XIX APPROPRIATION ACCOUNT AS  
13 REIMBURSEMENT FOR MEDICAID EXPENDITURES FOR  
14 MEDICAID EXPANSION SCHIP SERVICES.—Notwith-  
15 standing any other provision of law, all amounts appro-  
16 priated under title XXI and allotted to a State pursuant  
17 to subsection (b) or (c) of section 2104 of the Social Secu-  
18 rity Act (42 U.S.C. 1397dd) for fiscal years 1998 through  
19 2000 (including any amounts that, but for this provision,  
20 would be considered to have expired) and not expended  
21 in providing child health assistance or related services for  
22 which payment may be made pursuant to subparagraph  
23 (C) or (D) of section 2105(a)(1) of such Act (42 U.S.C.  
24 1397ee(a)(1)) (as amended by subsection (a)), shall be  
25 available to reimburse the Grants to States for Medicaid

1 account in an amount equal to the total payments made  
2 to such State under section 1903(a) of such Act (42  
3 U.S.C. 1396b(a)) for expenditures in such years for med-  
4 ical assistance described in subparagraphs (A) and (B) of  
5 section 2105(a)(1) of such Act (42 U.S.C. 1397ee(a)(1))  
6 (as so amended).

7 (d) CONFORMING AMENDMENTS.—

8 (1) Section 1905(b) (42 U.S.C. 1396d(b)) is  
9 amended in the fourth sentence by striking “the  
10 State’s allotment under section 2104 (not taking  
11 into account reductions under section 2104(d)(2))  
12 for the fiscal year reduced by the amount of any  
13 payments made under section 2105 to the State  
14 from such allotment for such fiscal year” and insert-  
15 ing “the State’s available allotment under section  
16 2104”.

17 (2) Section 1905(u)(1)(B) (42 U.S.C.  
18 1396d(u)(1)(B)) is amended by striking “and sec-  
19 tion 2104(d)”.

20 (3) Section 2104 (42 U.S.C. 1397dd), as  
21 amended by subsection (b), is further amended—

22 (A) in subsection (b)(1), by striking “and  
23 subsection (d)”;

24 (B) in subsection (c)(1), by striking “sub-  
25 ject to subsection (d),”.

1           (4) Section 2105(c) (42 U.S.C. 1397ee(c)) is  
2       amended—

3           (A) in paragraph (2)(A), by striking all  
4       that follows “Except as provided in this para-  
5       graph,” and inserting “the amount of payment  
6       that may be made under subsection (a) for a  
7       fiscal year for expenditures for items described  
8       in paragraph (1)(D) of such subsection shall  
9       not exceed 10 percent of the total amount of ex-  
10      penditures for which payment is made under  
11      subparagraphs (A), (C), and (D) of paragraph  
12      (1) of such subsection.”;

13          (B) in paragraph (2)(B), by striking “de-  
14      scribed in subsection (a)(2)” and inserting “de-  
15      scribed in subsection (a)(1)(D)”;

16          (C) in paragraph (6)(B), by striking “Ex-  
17      cept as otherwise provided by law,” and insert-  
18      ing “Except as provided in subparagraph (A) or  
19      (B) of subsection (a)(1) or any other provision  
20      of law,”.

21          (5) Section 2110(a) (42 U.S.C. 1397jj(a)) is  
22      amended by striking “section 2105(a)(2)(A)” and  
23      inserting “section 2105(a)(1)(D)(i)”.

24      (e)           TECHNICAL           AMENDMENT.—Section  
25      2105(d)(2)(B)(ii) (42 U.S.C. 1397ee(d)(2)(B)(ii)) is

1 amended by striking “enhanced FMAP under section  
 2 1905(u)” and inserting “enhanced FMAP under the  
 3 fourth sentence of section 1905(b)”.

4 (f) EFFECTIVE DATE.—The amendments made by  
 5 this section shall be effective as if included in the enact-  
 6 ment of section 4901 of the BBA (111 Stat. 552).

7 **SEC. 803. APPLICATION OF MEDICAID CHILD PRESUMPTIVE**  
 8 **ELIGIBILITY PROVISIONS.**

9 Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is  
 10 amended by adding at the end the following new subpara-  
 11 graph:

12 “(D) Section 1920A (relating to presump-  
 13 tive eligibility for children).”.

14 **TITLE IX—OTHER PROVISIONS**  
 15 **Subtitle A—PACE Program**

16 **SEC. 901. EXTENSION OF TRANSITION FOR CURRENT WAIV-**  
 17 **ERS.**

18 Section 4803(d)(2) of BBA is amended—

19 (1) in subparagraph (A), by striking “24  
 20 months” and inserting “36 months”;

21 (2) in subparagraph (A), by striking “the initial  
 22 effective date of regulations described in subsection  
 23 (a)” and inserting “July 1, 2000”; and

24 (3) in subparagraph (B), by striking “3 years”  
 25 and inserting “4 years”.

1 **SEC. 902. CONTINUING OF CERTAIN OPERATING ARRANGE-**  
2 **MENTS PERMITTED.**

3 (a) IN GENERAL.—Section 1894(f)(2) (42 U.S.C.  
4 1395eee(f)(2)) is amended by adding at the end the fol-  
5 lowing new subparagraph:

6 “(C) CONTINUATION OF MODIFICATIONS  
7 OR WAIVERS OF OPERATIONAL REQUIREMENTS  
8 UNDER DEMONSTRATION STATUS.—If a PACE  
9 program operating under demonstration author-  
10 ity has contractual or other operating arrange-  
11 ments which are not otherwise recognized in  
12 regulation and which were in effect on July 1,  
13 2000, the Secretary (in close consultation with,  
14 and with the concurrence of, the State admin-  
15 istering agency) shall permit any such program  
16 to continue such arrangements so long as such  
17 arrangements are found by the Secretary and  
18 the State to be reasonably consistent with the  
19 objectives of the PACE program.”.

20 (b) CONFORMING AMENDMENT.—Section 1934(f)(2)  
21 (42 U.S.C. 1396u–4(f)(2)) is amended by adding at the  
22 end the following new subparagraph:

23 “(C) CONTINUATION OF MODIFICATIONS  
24 OR WAIVERS OF OPERATIONAL REQUIREMENTS  
25 UNDER DEMONSTRATION STATUS.—If a PACE  
26 program operating under demonstration author-

1           ity has contractual or other operating arrange-  
 2           ments which are not otherwise recognized in  
 3           regulation and which were in effect on July 1  
 4           2000, the Secretary (in close consultation with,  
 5           and with the concurrence of, the State admin-  
 6           istering agency) shall permit any such program  
 7           to continue such arrangements so long as such  
 8           arrangements are found by the Secretary and  
 9           the State to be reasonably consistent with the  
 10          objectives of the PACE program.”.

11          (c) EFFECTIVE DATE.—The amendments made by  
 12          this section shall be effective as included in the enactment  
 13          of BBA.

14      **SEC. 903. FLEXIBILITY IN EXERCISING WAIVER AUTHORITY.**

15          In applying sections 1894(f)(2)(B) and  
 16          1934(f)(2)(B) of the Social Security Act (42 U.S.C.  
 17          1395eee(f)(2)(B), 1396u–4(f)(2)(B)), the Secretary of  
 18          Health and Human Services—

19               (1) shall approve or deny a request for a modi-  
 20          fication or a waiver of provisions of the PACE pro-  
 21          tocol not later than 90 days after the date the Sec-  
 22          retary receives the request; and

23               (2) may exercise authority to modify or waive  
 24          such provisions in a manner that responds promptly  
 25          to the needs of PACE programs relating to areas of

1 employment and the use of community-based pri-  
2 mary care physicians.

3 **Subtitle B—Outreach to Eligible**  
4 **Low-Income Medicare Bene-**  
5 **ficiaries**

6 **SEC. 911. OUTREACH ON AVAILABILITY OF MEDICARE**  
7 **COST-SHARING ASSISTANCE TO ELIGIBLE**  
8 **LOW-INCOME MEDICARE BENEFICIARIES.**

9 (a) OUTREACH.—

10 (1) IN GENERAL.—Title XI (42 U.S.C. 1301 et  
11 seq.) is amended by inserting after section 1143 the  
12 following new section:

13 “OUTREACH EFFORTS TO INCREASE AWARENESS OF THE  
14 AVAILABILITY OF MEDICARE COST-SHARING

15 “SEC. 1144. (a) OUTREACH.—

16 “(1) IN GENERAL.—The Commissioner of So-  
17 cial Security (in this section referred to as the ‘Com-  
18 missioner’) shall conduct outreach efforts to—

19 “(A) identify individuals entitled to bene-  
20 fits under the medicare program under title  
21 XVIII who may be eligible for medical assist-  
22 ance for payment of the cost of medicare cost-  
23 sharing under the medicaid program pursuant  
24 to sections 1902(a)(10)(E) and 1933; and



1           “(B) notify such individuals of the avail-  
2           ability of such medical assistance under such  
3           sections.

4           “(2) CONTENT OF NOTICE.—Any notice fur-  
5           nished under paragraph (1) shall state that eligi-  
6           bility for medicare cost-sharing assistance under  
7           such sections is conditioned upon—

8           “(A) the individual providing to the State  
9           information about income and resources (in the  
10          case of an individual residing in a State that  
11          imposes an assets test for such eligibility); and

12          “(B) meeting the applicable eligibility cri-  
13          teria.

14          “(b) COORDINATION WITH STATES.—

15          “(1) IN GENERAL.—In conducting the outreach  
16          efforts under this section, the Commissioner shall—

17               “(A) furnish the agency of each State re-  
18               sponsible for the administration of the medicaid  
19               program and any other appropriate State agen-  
20               cy with information consisting of the name and  
21               address of individuals residing in the State that  
22               the Commissioner determines may be eligible  
23               for medical assistance for payment of the cost  
24               of medicare cost-sharing under the medicaid

1           program pursuant to sections 1902(a)(10)(E)  
2           and 1933; and

3           “(B) update any such information not less  
4           frequently than once per year.

5           “(2) INFORMATION IN PERIODIC UPDATES.—

6           The periodic updates described in paragraph (1)(B)  
7           shall include information on individuals who are or  
8           may be eligible for the medical assistance described  
9           in paragraph (1)(A) because such individuals have  
10          experienced reductions in benefits under title II.”.

11          (2) AMENDMENT TO TITLE XIX.—Section  
12          1905(p) (42 U.S.C. 1396d(p)), as amended by sec-  
13          tion 710(a), is amended by adding at the end the  
14          following new paragraph:

15          “(6) For provisions relating to outreach efforts to in-  
16          crease awareness of the availability of medicare cost-shar-  
17          ing, see section 1144.”.

18          (b) GAO REPORT.—The Comptroller General of the  
19          United States shall conduct a study of the impact of sec-  
20          tion 1144 of the Social Security Act (as added by sub-  
21          section (a)(1)) on the enrollment of individuals for medi-  
22          care cost-sharing under the medicaid program. Not later  
23          than 18 months after the date that the Commissioner of  
24          Social Security first conducts outreach under section 1144  
25          of such Act, the Comptroller General shall submit to Con-

gress a report on such study. The report shall include such recommendations for legislative changes as the Comptroller General deems appropriate.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect one year after the date of the enactment of this Act.

## **Subtitle C—Maternal and Child Health Block Grant**

### **SEC. 921. INCREASE IN AUTHORIZATION OF APPROPRIATIONS FOR THE MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT.**

(a) IN GENERAL.—Section 501(a) (42 U.S.C. 701(a)) is amended in the matter preceding paragraph (1) by striking “\$705,000,000 for fiscal year 1994” and inserting “\$850,000,000 for fiscal year 2001”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on October 1, 2000.

## **Subtitle D—Diabetes**

### **SEC. 931. INCREASE IN APPROPRIATIONS FOR SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES AND INDIANS.**

(a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES.—Section 330B(b) of the Public Health Service Act (42 U.S.C. 254c–2(b)) is amended—

1           (1) by striking “Notwithstanding” and insert-  
2           ing the following:

3           “(1)           TRANSFERRED           FUNDS.—  
4           Notwithstanding”; and

5           (2) by adding at the end the following:

6           “(2) APPROPRIATIONS.—For the purpose of  
7           making grants under this section, there is appro-  
8           priated, out of any funds in the Treasury not other-  
9           wise appropriated—

10           “(A) \$70,000,000 for each of fiscal years  
11           2001 and 2002 (which shall be combined with  
12           amounts transferred under paragraph (1) for  
13           each such fiscal years); and

14           “(B) \$100,000,000 for fiscal year 2003.”.

15           (b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—  
16           Section 330C(c) of such Act (42 U.S.C. 254c-3(c)) is  
17           amended—

18           (1) by striking “Notwithstanding” and insert-  
19           ing the following:

20           “(1)           TRANSFERRED           FUNDS.—  
21           Notwithstanding”; and

22           (2) by adding at the end the following:

23           “(2) APPROPRIATIONS.—For the purpose of  
24           making grants under this section, there is appro-

1        appropriated, out of any money in the Treasury not other-  
 2        wise appropriated—

3                “(A) \$70,000,000 for each of fiscal years  
 4                2001 and 2002 (which shall be combined with  
 5                amounts transferred under paragraph (1) for  
 6                each such fiscal years); and

7                “(B) \$100,000,000 for fiscal year 2003.”.

8        (c) EXTENSION OF FINAL REPORT ON GRANT PRO-  
 9        GRAMS.—Section 4923(b)(2) of BBA is amended by strik-  
 10       ing “2002” and inserting “2003”.

11       **SEC. 932. APPROPRIATIONS FOR RICKY RAY HEMOPHILIA**  
 12                **RELIEF FUND.**

13        Section 101(e) of the Ricky Ray Hemophilia Relief  
 14        Fund Act of 1998 (42 U.S.C. 300e–22 note) is amended  
 15        by adding at the end the following: “There is appropriated  
 16        to the Fund \$475,000,000 for fiscal year 2001, to remain  
 17        available until expended.”.

18        **Subtitle E—Information on Nurse**  
 19                **Staffing**

20        **SEC. 941. POSTING OF INFORMATION ON NURSING FACIL-**  
 21                **ITY STAFFING.**

22        (a) MEDICARE.—Section 1819(b) (42 U.S.C. 1395i–  
 23        3(b)) is amended by adding at the end the following new  
 24        paragraph:

25                “(8) INFORMATION ON NURSE STAFFING.—

1           “(A) IN GENERAL.—A skilled nursing fa-  
 2           cility shall post daily for each shift the current  
 3           number of licensed and unlicensed nursing staff  
 4           directly responsible for resident care in the fa-  
 5           cility. The information shall be displayed in a  
 6           uniform manner (as specified by the Secretary)  
 7           and in a clearly visible place.

8           “(B) PUBLICATION OF DATA.—A skilled  
 9           nursing facility shall, upon request, make avail-  
 10          able to the public the nursing staff data de-  
 11          scribed in subparagraph (A).”.

12          (b) MEDICAID.—Section 1919(b) (42 U.S.C.  
 13          1395r(b)) is amended by adding at the end the following  
 14          new paragraph:

15               “(8) INFORMATION ON NURSE STAFFING.—

16               “(A) IN GENERAL.—A nursing facility  
 17               shall post daily for each shift the current num-  
 18               ber of licensed and unlicensed nursing staff di-  
 19               rectly responsible for resident care in the facil-  
 20               ity. The information shall be displayed in a uni-  
 21               form manner (as specified by the Secretary)  
 22               and in a clearly visible place.

23               “(B) PUBLICATION OF DATA.—A nursing  
 24               facility shall, upon request, make available to

1 the public the nursing staff data described in  
 2 subparagraph (A).”.

3 (c) EFFECTIVE DATE.—The amendments made by  
 4 this section shall take effect on January 1, 2003.

5 **Subtitle F—Adjustment of Multiem-**  
 6 **ployer Plan Benefits Guar-**  
 7 **anteed**

8 **SEC. 951. MULTIEMPLOYER PLAN BENEFITS GUARANTEED.**

9 (a) IN GENERAL.—Section 4022A(c) of the Employee  
 10 Retirement Income Security Act of 1974 (29 U.S.C.  
 11 1322a(c)) is amended—

12 (1) by striking “\$5” each place it appears in  
 13 paragraph (1) and inserting “\$11”;

14 (2) by striking “\$15” in paragraph (1)(A)(i)  
 15 and inserting “\$33”; and

16 (3) by striking paragraphs (2), (5), and (6) and  
 17 by redesignating paragraphs (3) and (4) as para-  
 18 graphs (2) and (3), respectively.

19 (b) EFFECTIVE DATE.—The amendments made by  
 20 this section shall apply to any multiemployer plan that has  
 21 not received financial assistance (within the meaning of  
 22 section 4261 of the Employee Retirement Income Security  
 23 Act of 1974) within the 1-year period ending on the date  
 24 of the enactment of this Act.

